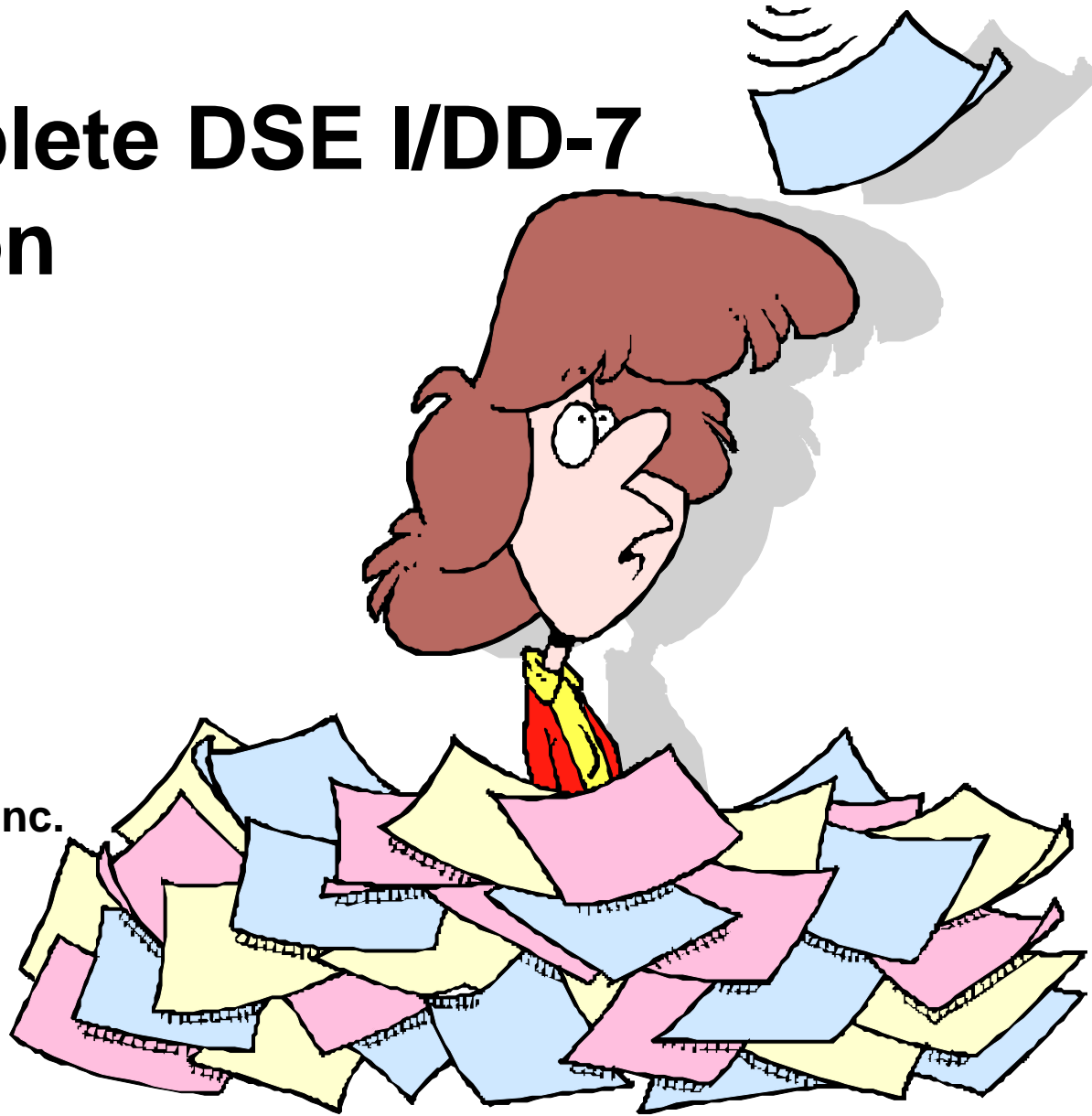
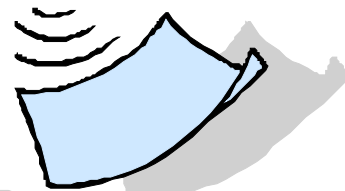


How To Complete DSE I/DD-7 Documentation

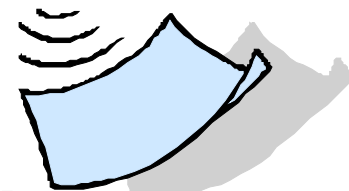


CSI: Community Services, Inc.
February 2013

- Download Adobe Reader XI at the following link:
<http://www.adobe.com/products/reader.html>
- This is a free program that will allow you to complete the DSE billing forms in a PDF format.
- **You MUST be using Adobe Reader XI for these forms to work.**



- You can access the forms on CSI's website under the "Documentation" link: www.csiwv.com
- Please be sure you choose the forms for the service you provide: PCSF, Respite or PCSA.
- Click the appropriate link and the form will pull up. You do not have to do anything special. **You do not have to click on any of the toolbars.** Just type your info into the form and/or choose the appropriate selection from the drop down list .



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.	
Month Of Service	December	Year Of Service	2012	
Service Name	Service Code	Identifier (ID)	Total Time For This Page	
Person Centered Supports Family 1:1	85125 US	1	Hours	Units
			0.00	0.00

IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED

Billing For Services For The Week Of:		December 15-21, 2012									
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

OFFICE USE:

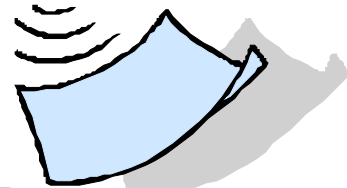
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

SC Notes:

1. Corrections Required To Service Log? YES NO
2. Billing Cut On Service Log? YES NO
3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
4. SC Initials: _____

Step 1: Type the first and last name of the client into this box.



WEST VIRGINIA IDD WAIVER
 DIRECT SUPPORT SERVICE LOG
 (To Be Used by Traditional And Agency With Choice Service Models)

Step 2: Click on the drop down box to select the correct month.

Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.			
Month Of Service	December		Year Of Service	2012			
Service Person Centered Support	May	<input type="button" value="Up"/> <input type="button" value="Down"/>	Identifier (ID)	Total Time For This Page			
	June			Hours	Units		
	July		1	0.00	0.00		
	August		B. TASK ANALYSIS MUST BE COMPLETED**				
Billing For Services	September		1, 2012				
	October						
	November						
	December						
Day	AM	Stop/Time	AM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider Staff Initials
Saturday							
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Provider/Staff Name:	Jill Jones		Person Centered Supports Family				
Provider/Staff Signature:	Signature On File						

WV/DIRS/IDD-7 Direct Support Service 2011 (CIS Rev. 12/2012) Date: ___/___/___

CLIENT NOTES:

1. Indicate if Billing is Late: LATE ON TIME

2. If Late, Date Submitted:

3. If Late, Time Submitted: AM PM

OFFICE USE:

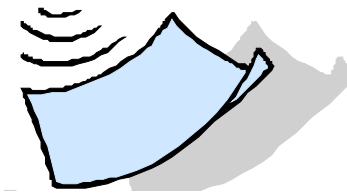
ISSUES:

1. Corrections Required To Service Log? YES NO

2. Billing Out Of Service Log? YES NO

3. If Yes, Why? Authorization/ID# Expired Overlapping Providers Duplicated Billing Work Provider Misadmission

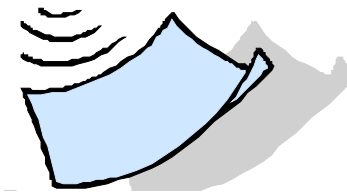
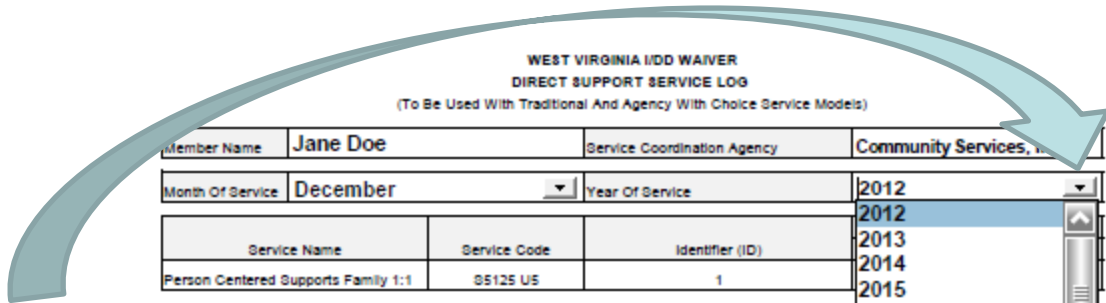
4. SC Initials:



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.						
Month Of Service	December	Year Of Service	2012							
Service Name	Service Code	Identifier (ID)		2012						
Person Centered Supports Family 1:1	05125 US	1		2013						
**IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED										
Billing For Services For The Week Of:	December 15-21, 2012									
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Monday	Tuesday	Wednesday
Saturday										
Sunday										
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Provider/Staff Name:	Jill Jones			Person Centered Supports Family						
Provider/Staff Signature:	Signature On File									

Step 3: Click on the drop down box to select the correct year.

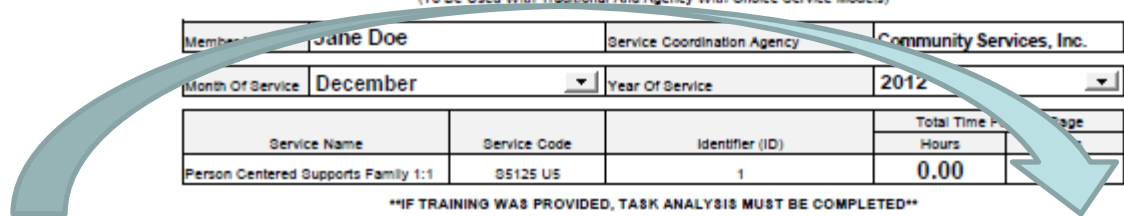


WW-BMS-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012) Page Of

Client Notes:		OFFICE USE:	
1. Indicate if Billing is Late: <input type="checkbox"/> LATE		SC Notes:	1. Corrections Required To Service Log? <input type="checkbox"/> YES <input type="checkbox"/> NO
2. If Late, Date Submitted: _____			2. Billing Cut On Service Log? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. If Late, Time Submitted: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			3. If Yes, Why? <input type="checkbox"/> Authorizations/IPP Exceeded <input type="checkbox"/> Overlapping Providers
			<input type="checkbox"/> Billed Outside Billing Week <input type="checkbox"/> Provider Miscalculation
			4. SC Initials: _____

**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Service Code	Identifier (ID)	Total Time Per Page Hours
Person Centered Supports Family 1:1	85125 US	1	0.00



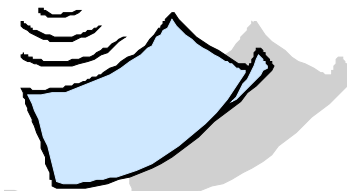
Step 4: Click on the drop down box to select the correct billing week.

****IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED****

Billing For Services For The Week Of:		December 15-21, 2012
Day	Date	December 15-21, 2012
Saturday		December 22-28, 2012
		December 29, 2012-January 4, 2013
Sunday		January 5-11, 2013
		January 12-18, 2013
		January 19-25, 2013
Monday		January 26-February 1, 2013
		February 2-8, 2013
Tuesday		
Wednesday		
Thursday		
Friday		

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

Client Notes:	OFFICE USE:
1. Indicate if Billing is Late: <input type="checkbox"/> LATE	1. Corrections Required To Service Log? <input type="checkbox"/> YES <input type="checkbox"/> NO
2. If Late, Date Submitted: _____	2. Billing Cut On Service Log? <input type="checkbox"/> YES <input type="checkbox"/> NO
3. If Late, Time Submitted: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	3. If Yes, Why? <input type="checkbox"/> Authorizations/IFP Exceeded <input type="checkbox"/> Overlapping Provider <input type="checkbox"/> Billed Outside Billing Week <input type="checkbox"/> Provider Miscalculation
	4. SC Initials: _____



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.	
Month Of Service	December	Year Of Service	2012	
Service Name	Service Code	Identifier (ID)	Total Time For This Page	
Person Centered Supports Fa	85125 US	1	Hours	Units
			0.00	0.00

TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED**

Billing For Services For The Week of December 15-21, 2012											
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

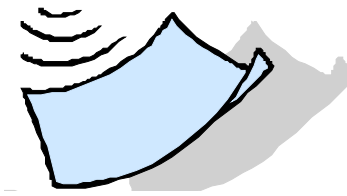
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

OFFICE USE:

- SC Notes:**
1. Corrections Required To Service Log? YES NO
 2. Billing Cut On Service Log? YES NO
 3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
 4. SC Initials: _____

Step 5: In this column, list the date that corresponds with the day listed in the "day" column. The date MUST be in the mm/dd/yyyy format. There are enough spaces for 3 entries per day.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.	
Month Of Service	December	Year Of Service	2012	
Service Name	Service Code	Identifier (ID)	Total Time For This Page	
Person Centered Supports Family	85125 US	1	Hours	Units
			0.00	0.00

IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED

Billing For Services For The Week Of December 15-21, 2012											
Day	Date	Identifier	Start Time	AM	Stop Time	AM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider Staff	Initials
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

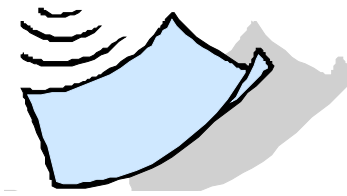
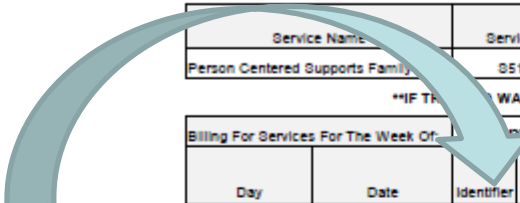
WV-BMS-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012)

Page _____ of _____

OFFICE USE:

- | | | | | |
|---------------------------------|---|---|--|--|
| Client Notes: | | SC Notes: | | |
| 1. Indicate if Billing is Late: | <input type="checkbox"/> LATE | 1. Corrections Required To Service Log? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. If Late, Date Submitted: | _____ | 2. Billing Cut On Service Log? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. If Late, Time Submitted: | _____ <input type="checkbox"/> AM <input type="checkbox"/> PM | 3. If Yes, Why? | <input type="checkbox"/> Authorizations/PP Exceeded | <input type="checkbox"/> Overlapping Provider |
| | | | <input type="checkbox"/> Billed Outside Billing Week | <input type="checkbox"/> Provider Miscalculation |
| | | 4. SC Initials: | _____ | |

Step 6: In this column, list the identifier. Note: Since we only list 1 service per page, the identifier is always "1".



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.	
Month Of Service	December	Year Of Service	2012	
Service Name	Service Code	Identifier (ID)	Total Time For This Page	
Person Centered Supports Family 1:1	US	1	Hours	Units
			0.00	0.00

IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED

Billing For Services For The Week Of: December 21, 2012												
Day	Date	Identifier	Start Time	AM	PM	Stop Time	AM	PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials
Saturday												
Sunday												
Monday												
Tuesday												
Wednesday												
Thursday												
Friday												

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

WV-BMS-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012)

Page _____ Of _____

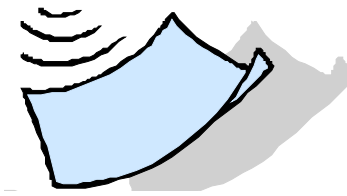
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

Office Use:

- SC Notes:
1. Corrections Required To Service Log? YES NO
 2. Billing Cut On Service Log? YES NO
 3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
 4. SC Initials: _____

Step 7: In this column, list the start time. It must be listed in the following format 00:00. For example: 9:15 or 10:00. Please use increments of no less than 5 minutes.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Code	Identifier (ID)	Total Time For This Page
Person Centered Supports Family 1:1	85129	1	Hours Units
			0.00 0.00

****IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED****

Billing For Services For The Week Of: December 12, 2012												
Day	Date	Identifier	Start Time	AM	PM	Stop Time	AM	PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials
Saturday												
Sunday												
Monday												
Tuesday												
Wednesday												
Thursday												
Friday												

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

WV-BMS-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012)

Page _____ Of _____

OFFICE USE:

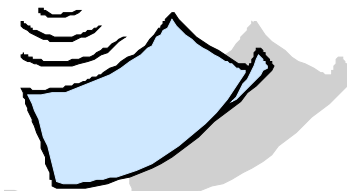
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

SC Notes:

1. Corrections Required To Service Log? YES NO
2. Billing Cut On Service Log? YES NO
3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
4. SC Initials: _____

Step 8: In this column, list "am" or "pm" to correspond with the start time.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Service Code	Identifier (ID)	Total Time For This Page
Person Centered Supports Family 1:1	85125 US	1	Hours Units
			0.00 0.00

IF TRAINING WAS PROVIDED, TRAINING HOURS MUST BE COMPLETED

Billing For Services For The Week Of: December 15-21, 2012												
Day	Date	Identifier	Start Time	AM	PM	Stop Time	AM	PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials
Saturday												
Sunday												
Monday												
Tuesday												
Wednesday												
Thursday												
Friday												

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

WV-BMS-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012)

Page _____ Of _____

Client Notes:

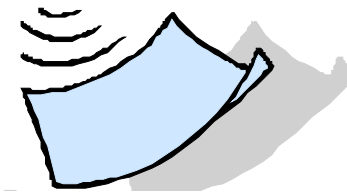
1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

Office Use:

SC Notes:

1. Corrections Required To Service Log? YES NO
2. Billing Cut On Service Log? YES NO
3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
4. SC Initials: _____

Step 9: In this column, list the stop time. It must be listed in the following format 00:00. For example: 9:15 or 10:00. Please use increments of no less than 5 minutes.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Service Code	Identifier (ID)	Total Time For This Page
Person Centered Supports Family 1:1	85125 US		Hours Units
			0.00 0.00

****IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED****

Billing For Services For The Week Of: December 15-21, 2012											
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

OFFICE USE:

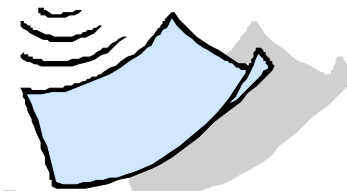
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

SC Notes:

1. Corrections Required To Service Log? YES NO
2. Billing Cut On Service Log? YES NO
3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
4. SC Initials: _____

Step 10: In this column, list "am" or "pm" to correspond with the stop time.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Service Code	Person ID	Total Time For This Page
Person Centered Supports Family 1:1	85125 US		Hours Units
			0.00 0.00

IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED

Billing For Services For The Week Of: December 15-21, 2012											
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

OFFICE USE:

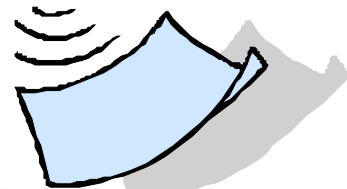
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

SC Notes:

1. Corrections Required To Service Log? YES NO
2. Billing Cut On Service Log? YES NO
3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
4. SC Initials: _____

Step 11: The total time in hours will automatically calculate in this column.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Service Code	Identifier (ID)	Total Time For This Page
Person Centered Supports Family 1:1	85125 US	1	Hours Units
			0.00 0.00

**IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED

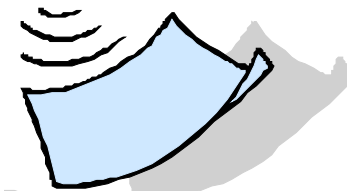
Billing For Services For The Week Of: December 15-21, 2012											
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

OFFICE USE:

- | | | | |
|---|--|---|--|
| Client Notes: | | SC Notes: | |
| 1. Indicate if Billing is Late: <input type="checkbox"/> LATE | | 1. Corrections Required To Service Log? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 2. If Late, Date Submitted: _____ | | 2. Billing Cut On Service Log? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 3. If Late, Time Submitted: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM | | 3. If Yes, Why? <input type="checkbox"/> Authorizations/PP Exceeded <input type="checkbox"/> Overlapping Provider | |
| | | <input type="checkbox"/> Billed Outside Billing Week <input type="checkbox"/> Provider Miscalculation | |
| | | 4. SC Initials: _____ | |

Step 12: The total time in units will automatically calculate in this column.



WEST VIRGINIA IDD WAIVER
 DIRECT SUPPORT SERVICE LOG
 (To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
Month Of Service	December	Year Of Service	2012
Service Name	Service Code	Identifier (ID)	Time For This Page
Person Centered Supports Family 1:1	05125 US	1	0.00
			Units
			0.00

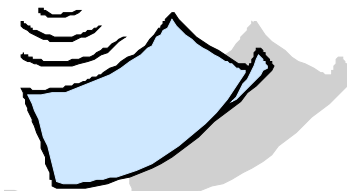
****IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED****

Billing For Services For The Week Of:		December 15-21, 2012									
Day	Date	Identifier	Start Time	AM	Stop Time	AM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

- Client Notes:**
- Indicate if Billing is Late: LATE
 - If Late, Date Submitted: _____
 - If Late, Time Submitted: _____ AM PM
- SC Notes:**
- Corrections Required To Service Log? YES NO
 - Billing Cut On Service Log? YES NO
 - If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
 - SC Initials: _____

Step 13: In this column, note if training was or was not provided. List "Y" for "yes" and "N" for "no." Remember, if "Y" is listed, you also need to submit monthly task analysis.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional and Agency With Choice Service Models)

Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.
Month Of Service	December		Year Of Service	2012
Service Name	Service Code	Identifier (ID)	Total Time (Hours)	Page
Person Centered Supports Family 1:1	05125 US	1	0.00	

****IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED****

Billing For Services For The Week Of:		December 15-21, 2012									
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Monday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

WV-808-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012)

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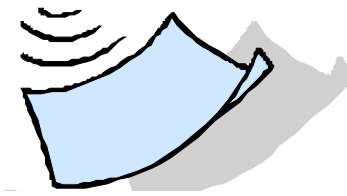
Client Notes:

1. Indicate if Billing is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

OFFICE USE:

- SC Notes:**
1. Corrections Required To Service Log? YES NO
 2. Billing Cut On Service Log? YES NO
 3. If Yes, Why? Authorizations/IPP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
 4. SC Initials: _____

Step 14: In this column, type your initials.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT SERVICE LOG**
(To Be Used With Traditional And Agency With Choice Service Models)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.	
Month Of Service	December	Year Of Service	2012	
Service Name	Service Code	Identifier (ID)	Total Time For This Page	
			Hours	Units
Person Centered Supports Family 1:1	05125 US	1	0.00	0.00

****IF TRAINING WAS PROVIDED, TASK ANALYSIS MUST BE COMPLETED****

Billing For Services For The Week Of:		December 15-21, 2012									
Day	Date	Identifier	Start Time	AM PM	Stop Time	AM PM	Total Time (Hours)	Total Time (Units)	Was Training Provided? (Y/N)	Provider/ Staff Initials	
Saturday											
Sunday											
Tuesday											
Wednesday											
Thursday											
Friday											

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

WW-8M8-IDD-7 Direct Support Service 2011 (CSI Rev. 12/2012)

Page Of

Client Notes:

1. Indicate if Billing Is Late: LATE
2. If Late, Date Submitted: _____
3. If Late, Time Submitted: _____ AM PM

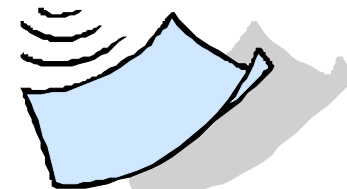
OFFICE USE:

SC Notes:

1. Corrections Required To Service Log? YES NO
2. Billing Cut On Service Log? YES NO
3. If Yes, Why? Authorizations/PP Exceeded Overlapping Provider
 Billed Outside Billing Week Provider Miscalculation
4. SC Initials: _____

Step 15:
Type your first and last name here, as the provider of the service.

Your signature is on file, so there is no need to electronically sign your form.

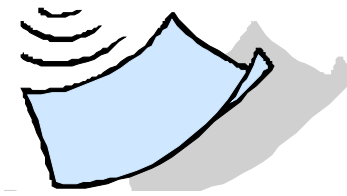


**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used With Traditional and Agency With Choice Service Models
And If Something Out Of The Ordinary Occurs While Providing Services)

Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.	
Month of Service	December		Year of Service	2012	
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? How did the member respond to support and services provided?					
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Provider/Staff Name:	Jill Jones		Person Centered Supports Family		
Provider/Staff Signature:	Signature On File				

This form is NOT required unless something out of the ordinary occurred.

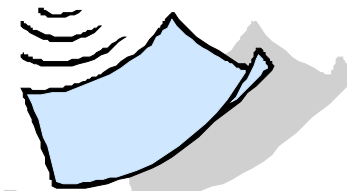
If so, please complete all required areas of the form.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used With Traditional and Agency With Choice Service Models
And If Something Out Of The Ordinary Occurs While Providing Services)

Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.	
Month of Service	December		Year of Service	2012	
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? How did the member respond to support and services provided?					
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Provider/Staff Name:	Jill Jones		Person Centered Supports Family		
Provider/Staff Signature:	Signature On File				

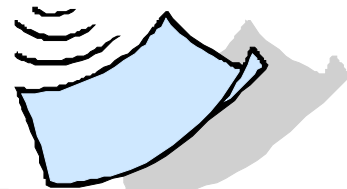
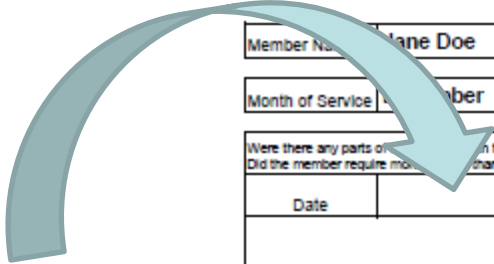
Step 1:
The member name, month of service and year of service are auto populated based on the information you keyed on page 1.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used With Traditional and Agency With Choice Service Models
And if Something Out Of The Ordinary Occurs While Providing Services)

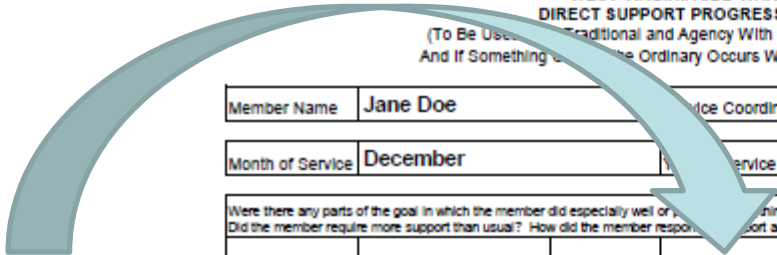
Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.	
Month of Service	Member	Year of Service	2012		
Were there any parts of the service that the member did especially well or poor? Did anything out of the ordinary occur (such as illness, behaviors, etc.)? Did the member require more support than usual? How did the member respond to support and services provided?					
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Provider/Staff Name:	Jill Jones		Person Centered Supports Family		
Provider/Staff Signature:	Signature On File				

Step 2: For each entry, enter the date. The date MUST be entered in the mm/dd/yyyy format.

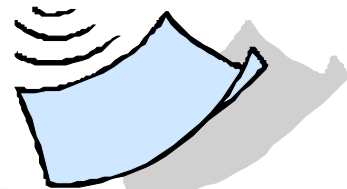


**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used for Traditional and Agency With Choice Service Models
And If Something Unusual or Out of the Ordinary Occurs While Providing Services)

Member Name	Jane Doe			Service Coordination Agency	Community Services, Inc.
Month of Service	December			Year of Service	2012
Were there any parts of the goal in which the member did especially well or something out of the ordinary occur (such as illness, behaviors, etc.)? Did the member require more support than usual? How did the member respond to support and services provided?					
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Provider/Staff Name:	Jill Jones			Person Centered Supports Family	
Provider/Staff Signature:	Signature On File				



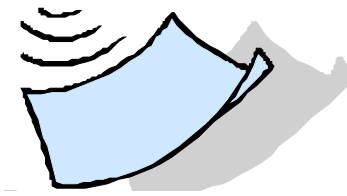
Step 3: For each entry, enter the time. It must be listed in the following format 00:00. For example: 9:15 or 10:00. Please use increments of no less than 5 minutes.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used With Transition and Agency With Choice Service Models
And If Something Out Of The Ordinary Occurs While Providing Services)

Member Name	Jane Doe		Service Provision Agency	Community Services, Inc.	
Month of Service	December		Year of Service	2012	
Were there any parts of the goal in which the member did especially well or poor? Did any extraordinary occur (such as illness, behaviors, etc.)? Did the member require more support than usual? How did the member respond to support and services provided?					
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Provider/Staff Name:	Jill Jones		Person Centered Supports Family		
Provider/Staff Signature:	Signature On File				

Step 4: For each entry, select "AM or "PM".



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT ACCESS NOTE**
(To Be Used With Traditional and Agency Waiver Service Models
And If Something Out Of The Ordinary Occurs While Providing Services)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
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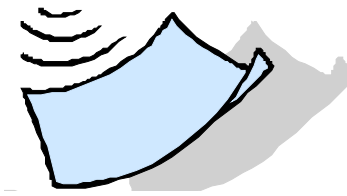
Month of Service	December	Year of Service	2012
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Were there any parts of the goal in which the member did especially well or poor? Did anything out of the ordinary occur (such as illness, etc.)? Did the member require more support than usual? How did the member respond to support and services provided?

Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
Provider/Staff Signature:	Signature On File	

Step 5: For each entry, type your initials.



**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used With Traditional and Agency With Choice Service Models
And If Something Out Of The Ordinary Occurs While Providing Services)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
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Month of Service	December	Year of Service	2012
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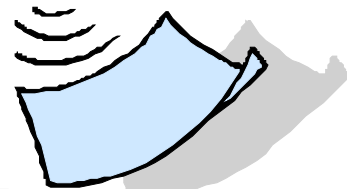
Were there any parts of the goal in which the member did especially well or poor? Did anything out of the ordinary occur (such as illness, behaviors, etc.)? Did the member require more support than usual? How did the member respond to support and services provided?

Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials

Step 6:
Document
what
occurred in
this box.

Provider/Staff Name:	Jill Jones	Person Centered Supports Family
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Provider/Staff Signature:	Signature On File
---------------------------	-------------------

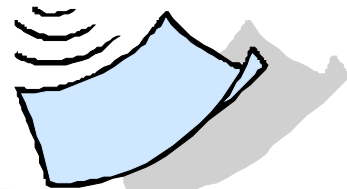


**WEST VIRGINIA IDD WAIVER
DIRECT SUPPORT PROGRESS NOTE**
(To Be Used With Traditional and Agency With Choice Service Models
And If Something Out Of The Ordinary Occurs While Providing Services)

Member Name	Jane Doe		Service Coordination Agency	Community Services, Inc.	
Month of Service	December		Year of Service	2012	
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? How did the member respond to support and services provided?					
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Date		Time		<input type="checkbox"/> AM <input type="checkbox"/> PM	Provider/Staff Initials
Provider/Staff Name:	Jill Jones		Person Centered Supports Family		
Provider/Staff Signature:	Signature On File				

Step 7: Your name will auto populate based on the info you entered on page 1.

Again, you do NOT have to sign your form.



**WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG**

(To Be Used With Traditional And Agency With Choice Service Delivery Models And If Applicable)

Service Code (Use Separate Pages For Miles And Trips): A0160 U1 (MILES) A0120 HI (TRIPS)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
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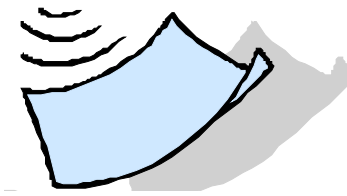
Month Of Service	December	Year Of Service	2012
------------------	----------	-----------------	------

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	☐ If Round Trip	Provider/ Staff Initials
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
					☐	
Total Miles For This Page						

Provider/Staff Name:	Person Centered Supports Family
Provider/Staff Signature:	

This form is not required unless you bill for transportation.

If you bill for transportation, you must have PRIOR authorization to do so.



WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG

(To Be Used With Traditional And Agency With Choice Service Delivery Models And If Applicable)

Service Code (Use Separate Pages For Miles And Trips): A0160 U1 (MILES) A0120 HI (TRIPS)

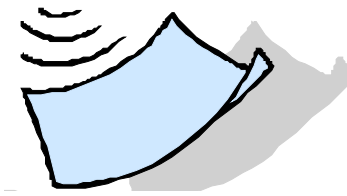
Member Name **Jane Doe** Service Coordination Agency **Community Services, Inc.**

Month Of Service **December** Year Of Service **2012**

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input checked="" type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Provider/Staff Name: _____ Person Centered Supports Family
 Provider/Staff Signature: _____

Step 1:
 The member name, month of service and year of service are auto populated based on the information you keyed on page 1.



WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG

(To Be Used With Traditional And Agency With Choice Service Delivery Models And If Applicable)

Service Code (Use Separate Pages For Miles And Trips): AD160 U1 (MILES) AD120 HI (TRIPS)

Member Name: Jane Doe **Service Coordination Agency:** Community Services, Inc.

Month Of Service: December **Year Of Service:** 2012

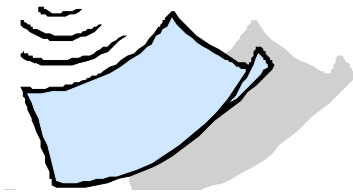
Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input checked="checked" type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Step 2:
For each entry, enter the date. The date **MUST** be entered in the mm/dd/yyyy format.

Provider/Staff Name: _____ **Person Centered Supports Family**

Provider/Staff Signature: _____

- | | | | | |
|------------------|--|--------------------|--|---|
| SC Notes: | 1. Corrections Required To Trans Log? <input type="checkbox"/> YES <input type="checkbox"/> NO | OFFICE USE: | 1. If Mileage Cut, Why? <input type="checkbox"/> Disbilled Outside Billing Week <input type="checkbox"/> Mileage Is Not Applicable | <input type="checkbox"/> Authorizations/PP Exceeded |
| | 2. Mileage Cut? <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> Provider Miscalculation | |



WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG

(To Be Used With Traditional And Agency With Choice Service Delivery Models And If Applicable)

Service Coordination Agency: Separate Pages For Miles And Trips: A0160 U1 (MILES) A0120 HI (TRIPS)

Member Name: _____ Service Coordination Agency: **Community Services, Inc.**

Month Of Service: _____ Year Of Service: **2012**

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

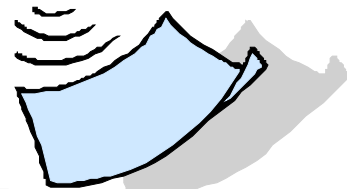
Travel From (Starting Location)	Travel To (End Location)
Client Home	Movie Theater
Dunbar	Cross Lanes

					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Provider/Staff Name: _____ Person Centered Supports Family
 Provider/Staff Signature: _____

- SC Notes: 1. Corrections Required To Trans Log? YES NO 3. If Mileage Cut, Why? Authorized/IPP Exceeded
 2. Mileage Cut? YES NO Disabled Outside Billing Week Provider Miscalculation
 Mileage Is Not Billable

Step 3:
For each entry, enter the travel FROM location. The top line is for the actual place. The bottom line is for the city/town. (See example).



WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG

(To Be Used With Additional And Agency With Choice Service Delivery Models And If Applicable)

Service Code (Use Separate Pages For Round Trips): AD160 U1 (MILES) AD120 HI (TRIPS)

Member Name: **Jane Doe** Service Coordination Agency: **Community Services, Inc.**

Month Of Service: **December** Year Of Service: **2012**

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Respond To An Objective On The Member's IPP)	Total Miles Or Trips	<input checked="" type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

Travel From (Starting Location)	Travel To (End Location)
Client Home	Movie Theater
Dunbar	Cross Lanes

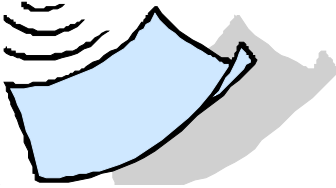
Total Miles For This Page:

Provider/Staff Name: **Person Centered Supports Family**
 Provider/Staff Signature:

WA-SMS-IDD-7 Direct Support Service 2011 (C/S) Rev. 12/2012 Date: Of

SC Notes:
 1. Corrections Required To Trans Log? YES NO
 2. Mileage Cut? YES NO
 OFFICE USE:
 3. If Mileage Cut, Why? Authorizations/IPP Exceeded
 Billing Outside Billing Week Provider Miscalculation
 Mileage Is Not Billable

Step 4: For each entry, enter the travel TO location. The top line is for the actual place. The bottom line is for the city/town. (See example).



WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG
(To Be Used With Traditional And With Choice Service Delivery Models And If Applicable)

Service Code (Use Separate Pages For Miles And Trips): A150 U1 (MILES) A0120 HI (TRIPS)

Member Name **Jane Doe** Service Code **A150 U1** Agency **Community Services, Inc.**

Month Of Service **December** Year Of Service **2012**

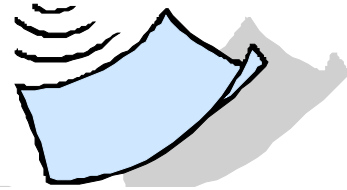
Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Provider/Staff Name: _____ Person Centered Supports Family

Provider/Staff Signature: _____

SC Notes: 1. Corrections Required To Trans Log? YES NO 2. Mileage Cut? YES NO OFFICE USE: 3. If Mileage Cut, Why? Billing Outside Billing Week Mileage Is Not Billable Authorizations/IPP Exceeded Provider Miscalculation

Step 5: For each entry, enter the reason for travel.



WEST VIRGINIA TRANSPORTATION MANAGER
(To Be Used With Traditional And Agency With Choice Service Models And If Applicable)

Service Code (Use Separate Pages For Miles And Trips): AD160 U1 (MILES) AD120 HI (TRIPS)

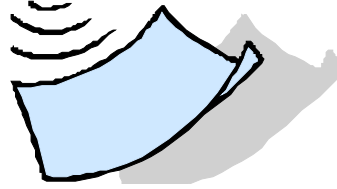
Member Name Jane Doe Service Coordination Agency Community Services, Inc.

Month Of Service December Year Of Service 2012

Step 6:
For each
entry, enter
the total
miles.

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
				Total Miles For This Page		

Provider/Staff Name: _____ Person Centered Supports Family
Provider/Staff Signature: _____



**WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG**
(To Be Used With Traditional And Agency With Choice Service Delivery Models (If Applicable))

Service Code (Use Separate Pages For Miles And Trips): AD160 U1 (MILES) AD160 U2 (PS)

Member Name	Jane Doe	Service Coordination Agency	Community Services
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Month Of Service	December	Year Of Service	2012
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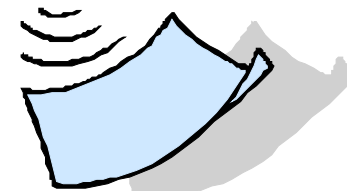
Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
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					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Provider/Staff Name:	Person Centered Supports Family
Provider/Staff Signature:	

WV-BMS-IDD-7 Direct Support Service 2011 (CS) Rev. 12/2012 Page Of

- | | | | | |
|--|--|--|--|---|
| SC Notes:
1. Corrections Required To Trans Log?
2. Mileage Cut? | <input type="checkbox"/> YES <input type="checkbox"/> NO | OFFICE USE:
<input type="checkbox"/> YES <input type="checkbox"/> NO | 3. If Mileage Cut, Why?
<input type="checkbox"/> Outside Billing Week
<input type="checkbox"/> Mileage Is Not Billable | <input type="checkbox"/> Authorization/IPP Exceeded
<input type="checkbox"/> Provider Miscalculation |
|--|--|--|--|---|

Step 7:
 For each
 entry,
 indicate
 here if the
 travel is for
 a round trip.



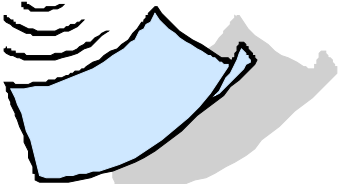
WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG

(To Be Used With Traditional And Agency With Choice Service Delivery Models And ...)

Service Code (Use Separate Pages For Miles And Trips): A0160 U1 (MILES) A0120 HI (HOURS)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.			
Month Of Service	December	Year Of Service	2012			
Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
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					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Step 8:
For each
entry, type
your initials.



**WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG**
(To Be Used With Traditional And Agency With Choice Service Delivery Models And If Applicable)

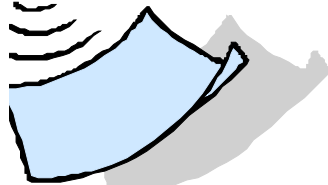
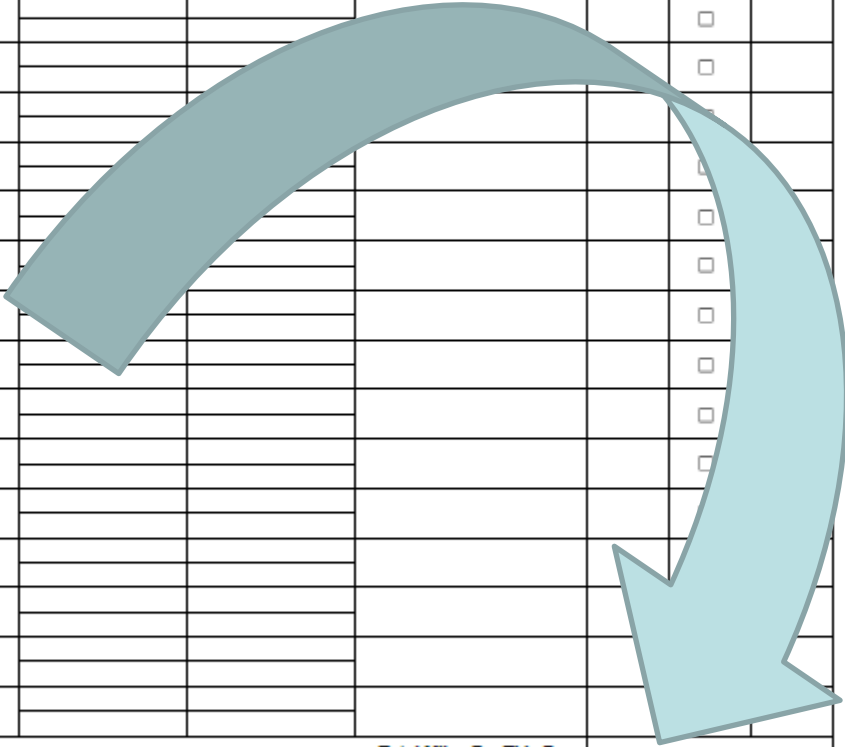
Service Code (Use Separate Pages For Miles And Trips): A0160 U1 (MILES) A0120 HI (TRIPS)

Member Name	Jane Doe	Service Coordination Agency	Community Services, Inc.
-------------	----------	-----------------------------	--------------------------

Month Of Service	December	Year Of Service	2012
------------------	----------	-----------------	------

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input checked="" type="checkbox"/> If Round Trip	Provider/Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
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					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
Total Miles For This Page						

Step 9:
Total miles
will auto
calculate
here.



Provider/Staff Name:	Person Centered Supports Family
Provider/Staff Signature:	

**WEST VIRGINIA IDD WAIVER
TRANSPORTATION LOG**
(To Be Used With Traditional And Agency With Choice Service Delivery Models And If Applicable)

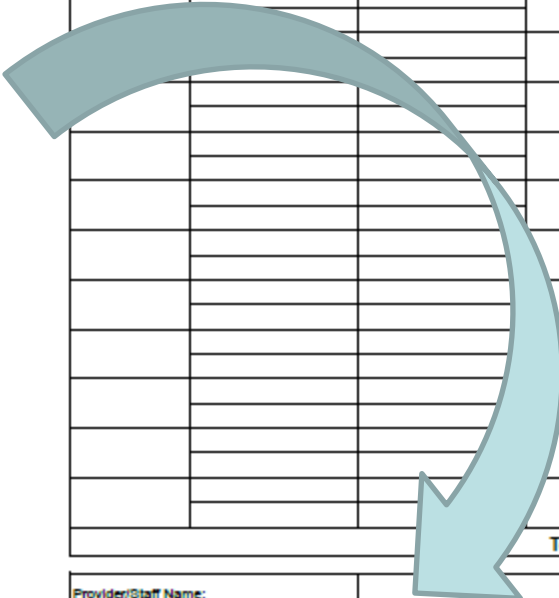
Service Code (Use Separate Pages For Miles And Trips): AD160 U1 (MILES) AD120 HI (TRIPS)

Member Name: **Jane Doe** Service Coordination Agency: **Community Services, Inc.**

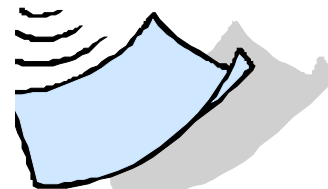
Month Of Service: **December** Year Of Service: **2012**

Step 10:
Your name
will auto
populate
based on
the info you
entered on
page 1.

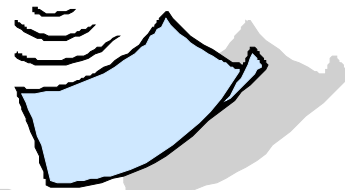
Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	<input type="checkbox"/> If Round Trip	Provider/ Staff Initials
					<input type="checkbox"/>	
					<input type="checkbox"/>	
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Total Miles For This Page						



Provider/Staff Name: _____ Person Centered Supports Family
 Provider/Staff Signature: _____



- Save the completed document. To do this, click on the icon that looks like a floppy disk toward the top left of the screen.
- Enter the file name (what you want to save your file as).
- Save as a .pdf file.
- Be sure you know where you have saved your file (on your desktop, in your documents, etc.).



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