WEST VIRGINIA I/DD WAIVER

DIRECT SUPPORT SERVICE LOG

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

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

Month Of Service		Year Of Service	

Service Name	Service Code	Identifier (ID)	Total Time For This Page	
			Hours	Units
Person Centered Supports Agency 1:1	S5125 U1	1		

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

Billing For Services For The Week Of:										
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:	Person Centered Supports Agency
Provider/Staff Signature:	

OFFICE USE:

Clerical 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/IPP Exceeded** ❑**Overlapping Providers** ❑**Billed Outside Billing Week** ❑**Provider Miscalculation**
4. **SC Initials:** _____

WEST VIRGINIA I/DD 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		Service Coordination Agency	**Community Services, Inc.**

Month of Service		Year of Service	

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		☐ AM ☐ PM	Provider/Staff Initials	
Date		Time		☐ AM ☐ PM	Provider/Staff Initials	
Date		Time		☐ AM ☐ PM	Provider/Staff Initials	
Date		Time		☐ AM ☐ PM	Provider/Staff Initials	
Date		Time		☐ AM ☐ PM	Provider/Staff Initials	

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

WEST VIRGINIA I/DD 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		Service Coordination Agency	**Community Services, Inc.**

Month Of Service		Year Of Service	

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

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

OFFICE USE:

SC Notes:

1. **Corrections Required To Trans Log?** ❑**YES** ❑**NO**
2. **Mileage Cut?** ❑**YES** ❑**NO**

3. **If Mileage Cut, Why?**
❑**Billed Outside Billing Week**
❑**Mileage Is Not Billable**
❑**Authorizations/IPP Exceeded**
❑**Provider Miscalculation**