WEST VIRGINIA I/DD WAIVER INTRODUCTORY INDIVIDUALIZED PROGRAM PLAN (Must be completed within seven days of intake for NEW slots only)

Name of Person who Receives Services:Date of I/DD waiver Enrollment:
(date slot received)
Upon eligibility determination (medical, financial and slot allocation) the following will be
implemented in order to initiate I/DD Waiver Services (use additional pages as necessary):
Service Code:
Service Description: Case Management: Traditional Option
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work: My Case Manager (CM) will provide linkage/referral to facilitate
access to I/DD Waiver Services. My CM will help me establish life-long, goal-oriented processes for
coordinating my natural and paid supports, range of services, and instruction and assistance that is
specific to my needs, wishes, desires and goals. My CM will provide service planning, advocacy, etc.
as outlined in the I/DD Waiver Manual.
Service Code:
Service Description:
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work:
Service Code:
Service Code: Service Description:
Provider:
Accessible/Available: Yes or No
Duration:
Amount/Frequency:
Plan of Action/Scope of Work:
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Plan of Action/Scope of Work:		
Service Code:		
Service Description:		
Provider:		
Accessible/Available: Yes or No		
Duration:		
Amount/Frequency:		
Plan of Action/Scope of Work:		
•		
Signature of Person Who Receives Services/Date	Legal Representative Signature/Date	
Gara Managara Cimadona ID.	Others/Date	
Case Manager Signature/Date	Other/Date	