West Virginia (WV) Children with Serious Emotional Disorders (CSED) Application for Waiver Services

At the time of application, applicants must:

- Be between three (3) and 21 years of age.
- WV residents at the date of submission.

Applicant Information

First Name, MI, Last Name		Date of Birth	
Medicaid Number (if applicable)		Gender	
Social Security Number			
Street Address (City, State, Zip Code) **Proof of residency must be attached*			
County of Current Residence		Out of State	
County of Medicaid Application			

How were you referred to the CSED Waiver?		Self/Personal Referral
School	Primary Care Provider (PCP)	BBH/Other MCO
Mental Health Provider	Probation	Court
CPS/Youth Services (YS)	Bureau for Juvenile Services (BJS)	Other
Is the applicant currently in a group residential setting?	Yes	No
If yes, the name of the residential setting		

Legal Representative Information of Child under Age 18

First Name, Last Name	
Phone Number	
Mailing Address	
Email Address	

<u>FOR DoHS USE ONLY</u>: Worker Information

First Name, Last Name		
Phone Number		
County		
Email Address		
Has a QIA (Qualified Independent Assessor Process) referral been made?	Yes	No

PATH Number (for children in foster care)	

FOR DoHS USE ONLY: District Supervisor Information

First Name, Last Name	
Phone Number	
County	
Email Address	

Non-Legal Representative Information (if applicable, i.e., foster parent)

First Name, Last Name	
Phone Number	
Mailing Address	
Email Address	

Applicant/Legal Representative Signature

By signing this form, you are consenting to be assessed for enrollment into the CSEDW program. **Proof of residency must be included with this application** including a photo ID or utility bill showing the WV physical address in the name of the applicant (or legal representative).

I certify the above information is accurate and complete to the best of my knowledge. I understand the information provide in this document will be treated confidentially and by signing this form, I am giving permission to be evaluated for the CSEDW program. I certify that the above-named applicant is permanent resident of West Virginia.

_____ **PLEASE PRINT** Name of Legal Representative or Applicant ONLY	_____ Date
_____ **SIGNATURE** of Legal Representative or Applicant ONLY	_____ Date

Form Submission (forms may be mailed, faxed, or emailed)

Mail: Acentra – 1007 Bullitt St. Suite 200 Charleston, WV 25301
Fax#: (866) 473 – 2354 **Email**: wvcsedw@acentra.com

If you have not heard from Acentra within 5 business days, please call (304) 343-9663 or 844-304-7107.