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| **SECTION 1: INDIVIDUAL INFORMATION** | | | | | | | | | | | | | | | | |
| Individual Name | | **First Name:**       **Last Name:** | | | | | | | | | | | | | | |
| Date Submitted | | Click here to enter a date. | | | | | | | | | | | | | | |
| Requested Start Date | | Click here to enter a date. | | | | | | | | | | | | | | |
| Individual DOB | |  | | | | | | | | | | | | | | |
| Individual Medicaid # | |  | | | | | | | | | | | | | | |
| Height/Weight | | **Height:**      **Weight:** | | | | | | | | | | | | | | |
| Current Medical Diagnosis | |  | | | | | | | | | | | | | | |
| Current DSM-V Diagnosis | |  | | | | | | | | | | | | | | |
| **SECTION 2: CSB/BEHAVIORAL HEALTH AUTHORITY INFORMATION** | | | | | | | | | | | | | | | | |
| CSB/BHA | | Choose an item. | | | | | | | | | | | | | | |
| CSB Support Coordinator | |  | | | | | | | | | | | | | | |
| CSB Support Coordinator Email | |  | | | | | | | | | | | | | | |
| CSB Support Coordinator Phone # | |  | | | | | | | | | | | | | | |
| **SECTION 3: PROVIDER INFORMATION** | | | | | | | | | | | | | | | | |
| Provider Name | |  | | | | | | | | | | | | | | |
| Provider Point of Contact | |  | | | | | | | | | | | | | | |
| Provider Business Address | | **Street Address or P.O.:**  **City, State, Zip:** | | | | | | | | | | | | | | |
| Address where supports will be provided | | **Street Address or P.O.:**  **City, State, Zip:** | | | | | | | | | | | | | | |
| Provider Phone and Fax # | | **Phone:**       **Fax:** | | | | | | | | | | | | | | |
| Provider Email | |  | | | | | | | | | | | | | | |
| Is the individual a former resident of a training center? | | **NVTC /Discharge Date:**       **SWVTC/Discharge Date:**  **SVTC/Discharge Date:**       **SEVTC/Discharge Date:**  **CVTC/Discharge Date:**       **N/A** | | | | | | | | | | | | | | |
| Under what service is a customized rate requested? | | **Group Day**  1:1 with specialized staffing  1:1 with standard staffing  **Community Coaching**  1:1 with specialized staffing  2:1 with two standard staff  2:1 with one standard staff and one specialized staff  2:1 with two specialized staff  **In-home Supports**  1:1 with specialized staffing  2:1 with two standard staff  2:1 with one standard staff and one specialized staff  2:1 with two specialized staff | | | | | | | | | | | | | | |
| **SECTION 4: STAFFING** | | | | | | | | | | | | | | | | |
| Credentials/Direct Support | | **Do any of the employed Direct Support Professionals have specialized credentials as follows:**   1. a college degree **or** 2. specialized licensing/certification such as CNA, RBT **or** 3. specialized training **or** 4. any combination of the above **AND** significant experience working with the population   Yes No  **If yes, please attach the employees credentials when submitting the application** | | | | | | | | | | | | | | |
| Have any additional Direct Support Professional with the above credentials been hired since the previous review period? | | Yes/If yes, please explain:  No | | | | | | | | | | | | | | |
| **SECTION 5:ONE TO ONE SUPPORT** | | | | | | | | | | | | | | | | |
| Provide an explanation of why 1:1 supports are needed and what risks might be present if these supports were not in place | | N/A, 1:1 supports not needed (Skip remainder of this section) | | | | | | | | | | | | | | |
| Provide a summary of any changes to 1:1 support needs that have occurred since the previous review | | N/A, no changes since the previous review period | | | | | | | | | | | | | | |
| List all supports which require direct 1:1 care, the frequency of the specific support, and the associated staff providing the support | | **Support** | | **Duration of Support (MINUTES)** | | | | | | **Frequency of Support (DAILY)** | | | | **Staff providing the Support** | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
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|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
|  | |  | | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
| **SECTION 6: TWO TO ONE SUPPORT** | | | | | | | | | | | | | | | | |
| Please give an explanation of why 2:1 supports are needed and what risks might be present if these supports were not in place | | N/A, 2:1 supports not needed (Skip the remainder of this section) | | | | | | | | | | | | | | |
| Provide a summary of any changes to 2:1 support needs that have occurred since the previous review | | N/A, no changes since the previous review period | | | | | | | | | | | | | | |
| List all supports which require direct 2:1 care, the frequency of the specific support, and the associated staff providing the support | | **Support** | | | **Duration of Support (MINUTES)** | | | | | **Frequency of Support (DAILY)** | | | | **Staff providing the Support** | | |
|  | | |  | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
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|  | | |  | | | | |  | | | | Direct Support Professional  LPN  RN  Other: | | |
| **SECTION 7: BEHAVIORAL SUPPORT** | | | | | | | | | | | | | | | | |
| Does individual have a current behavior support plan? | | Yes  No/ If no, and formal behavioral support is needed, please explain:  N/A, no behavioral support needs (Skip remainder of this section) | | | | | | | | | | | | | | |
| Have there been any updates to the behavioral support plan since the previous review period? | | Yes/ If yes Please explain:  No | | | | | | | | | | | | | | |
| Are behavior graphs that encompass the time since the previous approval provided with the application? | | Yes  No/If no please explain: | | | | | | | | | | | | | | |
| **Note in the 1st column** the primary challenging behaviors  **Note in 2nd column** the associated replacement behaviors  **Note in the 3rd column** if the frequency, duration, and/or intensity of behavior is increasing, decreasing, or stable over approximately the last 3 months | | **Challenging Behavior** | | | | | | **Associated Replacement Behavior** | | | | | | | | **Trend over the past 3 months** |
|  | | | | | |  | | | | | | | | Choose an item. |
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| Provide a description of challenging behaviors as it relates to changes to frequency, duration, and/or intensity since the previous review period | | N/A, no changes | | | | | | | | | | | | | | |
| **In the 1st column**, list behavioral interventions/therapies that have occurred over the past review period (e.g., specific behavior change tactics, direct ABA services, cognitive behavior therapy/other psychotherapies)  **In the 2nd column**, provide an estimated duration per week in hours/minutes for each intervention/therapy (e.g. dialectical behavior therapy: 5 hours per week) | | **Intervention** | | | | | | | | | | | | | **Duration per week** | |
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| Please explain new interventions/therapies that have been implemented since the previous review date | | N/A, no new intervention have been implemented | | | | | | | | | | | | | | |
| Over the past 6 months, have challenging behaviors resulted in injury to the individual or others? If so, please explain | | N/A, No injuries | | | | | | | | | | | | | | |
| Describe any history of hospitalizations, legal system involvement, or crisis services required over the past 12 months as a result of challenging behaviors. | | Event: | Date: | | | | | | Length: | | | Cause: | | | | |
| Event: | Date: | | | | | | Length: | | | Cause: | | | | |
| Event: | Date: | | | | | | Length: | | | Cause: | | | | |
| Event: | Date: | | | | | | Length: | | | Cause: | | | | |
| Event: | Date: | | | | | | Length: | | | Cause: | | | | |
| **SECTION 8: MEDICAL SUPPORT** | | | | | | | | | | | | | | | | |
| Does the individual have exceptional medical support needs? | Yes  No (Skip remainder of this section) | | | | | | | | | | | | | | | |
| Medical supports that are performed by a **Licensed Practical Nurse only** | **Support** | | | | | | | **Duration of Support (MINUTES)** | | | | | **Frequency of Support (DAILY)** | | | |
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| Please explain any changes as it relates to the above listed supports since the previous review period |  | | | | | | | | | | | | | | | |
| Medical supports that are performed by a **Registered Nurse only** | **Support** | | | | | **Duration of Support (MINUTES)** | | | | | | | **Frequency of Support (DAILY)** | | | |
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| Please explain any changes as it related to the above listed supports since the previous review period |  | | | | | | | | | | | | | | | |
| Medical supports that are delegated to a **Direct Support Processional or Certified Nursing Assistant** | **Support** | | | | | | **Duration of Support (MINUTES)** | | | | | | **Frequency of Support (DAILY)** | | | |
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| Please explain any changes as it relates to the above listed supports since the previous review period |  | | | | | | | | | | | | | | | |
| History of hospitalizations over the past 12 months | Date: | | Length of stay: | | | | | | | | Cause: | | | | | |
| Date: | | Length of Stay: | | | | | | | | Cause: | | | | | |
| Date: | | Length of Stay: | | | | | | | | Cause: | | | | | |
| Date: | | Length of Stay: | | | | | | | | Cause: | | | | | |
| Date: | | Length of Stay: | | | | | | | | Cause: | | | | | |
| Does the individual receive any other services such as Hospice or Wound Care Specialist | Yes No  If yes, Please Explain:  **Is this a change from the previous review Period?** Yes No | | | | | | | | | | | | | | | |
| **SECTION 9: DAY ACTIVITIES** | | | | | | | | | | | | | | | | |
| **List the hours per day that the individual is involved in any of the below activities** | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Employment/**  **Volunteering** | **Community Coaching** | **Community Engagement** | **Group Day** | **Other Services** | | **Monday** |  |  |  |  |  | | **Tuesday** |  |  |  |  |  | | **Wednesday** |  |  |  |  |  | | **Thursday** |  |  |  |  |  | | **Friday** |  |  |  |  |  | | **Saturday** |  |  |  |  |  | | **Sunday** |  |  |  |  |  | | | | | | | | | | | | | | | | | |
| List any barriers to participation in day services |  | | | | | | | | | | | | | | | |
| What actions have been taken to address these barriers since the last review period? |  | | | | | | | | | | | | | | | |
| Specific to the requested service, list the individual’s skill building outcomes |  | | | | | | | | | | | | | | | |
| Specific to the requested service, list barriers to achieving skill building outcomes |  | | | | | | | | | | | | | | | |
| Specific to the requested service, list actions that have been taken to address barriers to skill building outcomes |  | | | | | | | | | | | | | | | |
| List any positive outcomes that have occurred as a result of implemented strategies to address barriers |  | | | | | | | | | | | | | | | |
| **SECTION 10: FUNDING NEED** | | | | | | | | | | | | | | | | |
| Describe what efforts have been made to reduce the need for 1:1 or 2:1 supports |  | | | | | | | | | | | | | | | |
| Describe how the customized rate has positively affected the individual as it relates to overall medical and/or behavioral challenges |  | | | | | | | | | | | | | | | |
| If recommendations were made by the Customized Rate Review Committee within the Notice of Action Form, please explain what attempts have been made to adopt these recommendations | No recommendations were made in the Notice of Action form at the previous review  All recommendations were adopted  Some, but not all recommendations were adopted/If checked please explain:  None of the recommendations made within the Notice of Action form were adopted/If checked, please explain: | | | | | | | | | | | | | | | |
| List any additional information that has not already been explained |  | | | | | | | | | | | | | | | |
| **SECTION 11: SUPPORTING DOCUMENTATION** | | | | | | | | | | | | | | | | |
| **The following documentation is REQUIRED with all applications, where applicable. Please check all documents that are attached with this application. Where not attached, provide an explanation.**  **ISP Parts I through IV and the provider completed Plan for Supports (Part V)**  Submitted  Not submitted/Explanation:  **Behavioral Support Plan**-Required of all applicants requesting supports related to challenging behaviors  Submitted  Not submitted/Explanation:  **Behavioral Data**-Required of all applicants requesting supports related to challenging behaviors  Submitted  Not submitted/Explanation:  **Health supports data**-Required of all applicants requesting supports related to challenging medical supports and should include medical protocols, medication administration records, records of hospitalization or physician summaries, and/or other critical medical documentation.  Submitted  Not submitted/Explanation:  **Most recent quarterly-**Required of all applicants  Submitted  Not submitted/Explanation:  **Staff credentials**-Credentials are only required for staff meeting the criteria of “specialized staffing”  Submitted  Not submitted/Explanation:  **Crisis plan**-Required of all applicants requesting supports related to challenging behaviors  Submitted  Not submitted/Explanation:  **Overnight support’s data-** Required of all applicants  Submitted  Not submitted/Explanation:  **DBHDS Supplemental form (FORM SFD-18)-** This supplemental form can be found at [www.dbhds.virginia.gov](http://www.dbhds.virginia.gov) and is required of all applicants  Submitted  Not submitted/Explanation: | | | | | | | | | | | | | | | | |