|  |
| --- |
| **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:       |
|       |       |       | [ ] Direct Support Professional[ ] LPN[ ] RN[ ] Other:       |
|       |       |       | [ ] 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:       |
|       |       |       | [ ] 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:       |
|       |       |       | [ ] 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. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
|       |       | Choose an item. |
| 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 [ ] NoIf 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:       |