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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** | | | | | | | | | | | | | | | | | |
| How many individuals is the home licensed to support? | | Choose an item. | | | | | | | | | | | | | | | | | |
| How many individuals are currently supported in the home? | | Choose an item. | | | | | | | | | | | | | | | | | |
| Under what service is a customized rate requested? | | Choose an item. | | | | | | | | | | | | | | | | | |
| Which supports are requested? | | **One to One Supports**  1:1 with Specialized Staffing **OR**  1:1 with Standard Staffing  **Two to One Supports**  2:1 with Specialized Staffing **OR**  2:1 with Standard Staffing **OR**  2:1 with One standard Staff and One Specialized Staff  **Program Oversight** | | | | | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | | | | | |
| Have any additional **Direct Support Professional** with the above credentials/training been hired since the previous review period? | | Yes/If yes, please explain:  No | | | | | | | | | | | | | | | | | |
| The individual requires programmatic oversight for expertise that is not available through contracting for professionals which are Medicaid Waiver vendors | | Yes/Give a detailed description of the specific supports required:  No | | | | | | | | | | | | | | | | | |
| Credentials/Program Oversight | | **Does the provider employ programmatic staff who have specialized credentials as follows:**   1. A Master’s level degree **or** 2. Bachelor’s level degree with additional certifications in specific areas of expertise, (e.g., BCBA certification/LABA license) **AND** 3. This expertise is not available through contracting for professionals which are Medicaid waiver vendors **AND** 4. Staff are required to have a higher level of expertise than routinely required by QDDP in order to provide the required oversight and supervision of all of the key programmatic elements related to the individual's exceptional support needs   Yes No    **Has any additional programmatic staff with the above credentials been hired since the previous review period?**  Yes/If yes, please explain:  No, (Skip remainder of this section)  **Please check all that apply for staffed positions meeting the above criteria for which a customized rate is requested:**   |  |  | | --- | --- | | **Provides direct support staff training, especially as it relates to changes in care plan; training which is evidenced based and/or evidence driven requiring adherence to support protocols.** | | | Staff Name |  | | Staff Credentials |  | | Number of individuals supported in all programs/homes |  | | Average time per month spent with or for the individual who is applying for the customized rate |  | | Summary of supports provided |  |  |  |  | | --- | --- | | **Develops protocols and implements the processes that deliver effective and safe, evidence driven interventions/plans of care resulting in outcomes that improve the daily life of the individual.** | | | Staff Name |  | | Staff Credentials |  | | Number of individuals supported in all programs/homes |  | | Average time per month spent with or for the individual who is applying for the customized rate |  | | Summary of supports provided |  |  |  |  | | --- | --- | | **Monitors medical and/or behavioral data to assure proper implementation of protocols, including changing the protocols as needed as an individual navigates his or her environment successfully.** | | | Staff Name |  | | Staff Credentials |  | | Number of individuals supported in all programs/homes |  | | Average time per month spent with or for the individual who is applying for the customized rate |  | | Summary of supports provided |  |  |  |  | | --- | --- | | **Serves as a liaison and provides expert opinion during hospitalizations or crisis interventions to ensure that protocols are maintained and/or amended as needed to reduce or prevent future hospitalizations (whether medical or behavioral). For individuals with a history of, or who are at risk of law enforcement involvement; staff must ensure that law enforcement and others are advised, trained or connected to mitigate the risk of legal system involvement or action.** | | | Staff Name |  | | Staff Credentials |  | | Number of individuals supported in all programs/homes |  | | Average time per month spent with or for the individual who is applying for the customized rate |  | | Summary of supports provided |  |  |  |  | | --- | --- | | **Oversees overall medical or behavioral supports to ensure supports are effective and coordinated with external providers, CSBs, emergency services and that protocols address when and how to involve external providers.** | | | Staff Name |  | | Staff Credentials |  | | Number of individuals supported in all programs/homes |  | | Average time per month spent with or for the individual who is applying for the customized rate |  | | Summary of supports provided |  | | | | | | | | | | | | | | | | | | |
| **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 | | Yes/Description:  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 | | | | | | | | | | | | | | | | | |
| List all supports which require direct **1:1 care**, the **frequency** of the specific support, and the **associated staff** providing the support  List **only** one per row | | **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: |
| Indicate the 1:1 hours per day that are requested under the customized rate for **direct support** | | **Total requested 1:1 with standard staffing** | | | | | | | | | | | **Total requested 1:1 with specialized staffing** | | | | | | |
|  | | Monday | | | | | | | | |  | | | | Monday | | |
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|  | | | Sunday | | | | | | | |  | | | Sunday | | | |
| If the above request has changed from the previous review period, provide an explanation | | N/A, no changes in the request | | | | | | | | | | | | | | | | | |
| **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 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 | | | | | | | | | | | | | | | | | |
| List all supports which require direct **2:1 care**, the **frequency** of the specific support, and the **associated staff** providing the support  List **only** one per row | | **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: |
| Indicate the 2:1 hours per day that are requested under the customized rate for **direct support** | | **Total requested 2:1 with standard staffing** | | | | | | | | | | **Total requested 2:1 with specialized staffing** | | | | | | | |
|  | Monday | | | | | | | | |  | | | Monday | | | | |
|  | Tuesday | | | | | | | | |  | | | Tuesday | | | | |
|  | Wednesday | | | | | | | | |  | | | Wednesday | | | | |
|  | Thursday | | | | | | | | |  | | | Thursday | | | | |
|  | Friday | | | | | | | | |  | | | Friday | | | | |
|  | Saturday | | | | | | | | |  | | | Saturday | | | | |
|  | Sunday | | | | | | | | |  | | | Sunday | | | | |
| If the above request has changed from the previous review period, provide an explanation | | N/A, no changes | | | | | | | | | | | | | | | | | |
| **SECTION 7: BEHAVIORAL SUPPORT** | | | | | | | | | | | | | | | | | | | |
| Does the individual have a current behavior support plan? | | Yes  No/ If no and a formal behavior support is needed, please explain:  N/A, no behavior 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 this 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  List **only** one per row | | **Challenging Behavior** | | | | | | **Associated Replacement Behavior** | | | | | | | | | | | **Trend over the past 3 months** |
|  | | | | | |  | | | | | | | | | | | Choose an item. |
|  | | | | | |  | | | | | | | | | | | Choose an item. |
|  | | | | | |  | | | | | | | | | | | Choose an item. |
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|  | | | | | |  | | | | | | | | | | | Choose an item. |
| Provide a description of challenging behaviors as it relates to changes in frequency, duration, and/or intensity since previous review period | |  | | | | | | | | | | | | | | | | | |
| **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 any new interventions/therapies that have been implemented since the previous review date | | N/A, no new interventions | | | | | | | | | | | | | | | | | |
| Over the past 6 months has challenging behavior resulted in injury to the individual or others? If so, please describe. | | N/A, no injury | | | | | | | | | | | | | | | | | |
| Describe any history of hospitalizations, legal system involvement, or crisis services required since the previous review period 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**  List **only** one per row | **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 | N/A, no changes | | | | | | | | | | | | | | | | | | |
| Medical supports that are performed by a **Registered Nurse only**  List **only** one per row | **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 | N/A, no changes | | | | | | | | | | | | | | | | | | |
| Medical supports that are delegated to a **Direct Support Professional or Certified Nursing Assistant**  List **only** one per row | **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 | N/A, no changes | | | | | | | | | | | | | | | | | | |
| History of hospitalizations since previous review period | 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 supports from a Wound Care Specialist? | Yes/Please Explain:  No  **Is this a change since the previous review period:**  Yes/If yes please explain:  No | | | | | | | | | | | | | | | | | | |
| **SECTION 9: OVERNIGHT SUPPORT** | | | | | | | | | | | | | | | | | | | |
| How many hours does the individual typically sleep at night? | **Is this a change since the previous review period:**  Yes/If yes please explain:  No | | | | | | | | | | | | | | | | | | |
| Does the individual have a consistent pattern of daytime sleeping? | Yes No  If yes, Please Explain:  **Is this a change since the previous review period:**  Yes/If yes please explain:  No | | | | | | | | | | | | | | | | | | |
| Describe overnight support needs to include any 1:1 or 2:1 staffing requirements  List **only** one per row | **Support** | | | | | | | | | **Duration of Support (MINUTES)** | | | | | | | | | **Frequency of Support (NIGHTLY)** |
|  | | | | | | | | |  | | | | | | | | |  |
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| Please explain any changes as it relates to the above listed supports since the previous review period | N/A, no changes | | | | | | | | | | | | | | | | | | |
| **SECTION 10: 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 | N/A, Individual does not have any barriers to participation in day services | | | | | | | | | | | | | | | | | | |
| What actions have been taken to address these barriers since the last review period | N/A, Individual does not have any barriers to participation in day services | | | | | | | | | | | | | | | | | | |
| **SECTION 11: FUNDING** | | | | | | | | | | | | | | | | | | | |
| Describe any barriers to bringing needed supports to the individual | N/A, Individual does not have any barriers to accessing needed supports | | | | | | | | | | | | | | | | | | |
| What actions have been taken to address these barriers since the last review period? | N/A, Individual does not have any barriers to accessing needed supports | | | | | | | | | | | | | | | | | | |
| Describe what efforts have been made to reduce the need for 1:1 or 2:1 supports | N/A-No actions have been taken to reduce the need for 1:1 or 2:1 supports/Explanation: | | | | | | | | | | | | | | | | | | |
| How much funding per day, above the standard rate is required to provide necessary safety supports? | **Is this an increase from the previous review period?**  Yes/If yes please explain:  No  **Is this a decrease from the previous review period?**  Yes/If yes please explain:  No | | | | | | | | | | | | | | | | | | |
| 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 12: 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 SFR-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: | | | | | | | | | | | | | | | | | | | |