***Human Rights Committee (HRC) Behavior Plan/Protocol Approval Request***

Individual’s Name: (Client First name last name) Duck #: (Client’s duck number)

Provider Agency(s): (Vendor Agency Name) Guardian: (Guardian first name last name)

Date of Plan Submission: (date plan was submitted to HRC) Date of Plan: (date author wrote plan)

***Reason for Submission:*** (Select one below. Plan submissions as listed below are mandatory. Plans or termination of plans cannot be implemented without written HRC and guardian approval.)

New Plan/ Protocol (1st plan for individual- no prior plan or new vendor taking over plan from other agency)

Annual Re-Approval **with changes** (must highlight changes) (reauthorization of current plan with highlighted revisions)

Emergency/Interim Plan/ Protocol (short-term/ immediate approval)

Annual Re-Approval **without changes** (re-authorization of current plan with no revisions)

Current Plan/ Protocol Extension Request (expired plan seeking extension)

Plan/ Protocol Termination (plan is no longer needed or utilized, so requesting to terminate plan)

Current Plan/ Protocol Revision (mid-approval change to plan)

PRN Protocol (plan only contains PRN protocol)

***Current Submission packet includes:*** (select all that apply. If individual/ program has any of the below listed items, they are required to be submitted with the plan)

Current Plan/ Protocol (the behavior plan seeking approval)

Summary & Analysis of Current Data for Review (Required for any type of plan authorization, modification or termination. Must include both the data and a summary as to what the data shows. Data graphs/ charts must be legible. Please remember that not all agencies have color printers.)

Blank Data Collection Sheet (if applicable) (e.g. tracking sheet, abc sheet, etc.)

Current Medication List (must be current as of the date the plan was submitted)

House Policies (if applicable) (e.g. rules for staffed residence that applies to everyone in home)

Psychotropic PRN Protocol (submit actual PRN Protocol written by the Nurse or doctor)

START/ Risk/ Mental Health Plan (if applicable) (submit copy of actual plan- used as reference & to ensure consistency)

Psychotropic PRN Medication Order (if applicable) (photocopy of actual order from prescriber)

***Restrictive Procedures:*** *(*please check all that apply): (these include any restrictive interventions included in the plan. Must include justification for each restriction within plan)

Physical Intervention (e.g. MANDT, MOAB, etc.)

Mechanical Intervention/ Adaptive Equipment (e.g. modified seatbelt that can’t be easily unlocked, harness in car, etc.)

Chemical (PRN) Intervention (e.g. psychotropic med used as stated in the plan)

Environmental Restrictions (e.g. audio/ video monitor, locks on cabinets or doors, window and door chimes, locked sharps/ other items, safety locks in car, GPS/ tracking device, etc.)

Use of Protective Clothing/equipment (e.g. helmet, mitts on hands, Kevlar sleeves, smoking vests, weighted blanket, bed rails, blocking pads, etc.)

Other:

***Summary of Circumstances:***

(Provide brief description of the needs and or challenges that the individual experiences that necessitate this plan/ protocol. Provide a brief synopsis as to why this plan, protocol or termination is being requested. If there are changes being made to the plan, provide a very brief explanation as to what and why it is being revised.)

I have reviewed this plan which was developed and/reviewed by all team members including guardian & agree with its submission for approval to the Human Rights Committee. Once approved by the HRC, I must have written informed consent by Guardian/Individual & Provider/Staff training must occur **prior** to the plan’s implementation. This documentation must be held by the Vendor/Program and submitted to the Area Agency.

Plan Author Signature: (Must be signed prior to submission) Date: (Month/ Day/ Year)

Printed Name: (First Name Last Name) Email Address:       Phone:

Program Administrator Signature: (Must be signed prior to submission) Date: (Month/ Day/ Year)

Printed Name: (First Name Last Name) Email Address:       Phone:

Program Administrator Signature: (Must be signed prior to submission. The second PA signature is required if there are 2 vendors or programs utilizing the plan/ protocol) Date: (Month/ Day/ Year)

For Service Coordinator Only:

I have reviewed the completed approval request cover sheet, plan and support data. I am in agreement with the team that the plan submission is complete, is in the best interest of the individual and request that it be reviewed by the HRC.

Service Coordinator Signature: (Must be signed prior to submission) Printed Name: (First Name Last Name) Date: (Month/ Day/ Year)

Printed Name: (First Name Last Name) Email Address:       Phone:

***Individual’s Name/Duck #:*** (Client First Name Last Name/ Duck Number) **Level:** 1 2 3  N/A (Check one box)

***HRC Decision:***

Emergency Approval Until Next Available HRC Meeting (Crisis need for immediate approval of behavior plan/ protocol; extension of current plan/ protocol; transfer of plan/ protocol to a new vendor that needs emergency approval; any plan/ protocol that falls outside of the regular HRC meeting and needs approval.)

Approval Begins: (Month/ Day/ Year) Approval Expires: (Month/ Day/ Year)

Temporary Approval With Follow Up Needed (See HRC comments and Provider Follow-up Required) (Plan/ protocol was reviewed by HRC, given short-term approval, and additional edits or follow-up must be completed by expiration date.)

Approval Begins: (Month/ Day/ Year) Approval Expires: (Month/ Day/ Year)

Full Approval (Plan/ protocol was reviewed by HRC and approval was granted for the time frame indicated below)

Approval Begins: (Month/ Day/ Year) Approval Expires: (Month/ Day/ Year)

Plan Termination Approved (Plan/ protocol was approved to be terminated as per the request of the Provider Agency)- Date: (Month/ Day/ Year)

Not Approved- (Plan/ protocol was reviewed by HRC and not approved for implementation for the reason(s) stated below) Date: (Month/ Day/ Year)

Reason: (Rationale for not approving plan/ protocol)

***HRC Comments:***

(Any general comments, concerns, etc. from the HRC in regards to the behavior plan/ protocol)

***Provider Agency Follow-up Required: (check all that apply below)***

Current Medication List Needed (see above) Current Plan Needed (plan submitted was not correct/ current version)

Blank Data Collection Sheet Needed (see above)

Termination Criteria Needed (plan missing requirements for fade/ termination of interventions) HRC Approval Request Cover Sheet Needed (missing this document or signatures on document)

Other Follow-up Needed- Describe Below:

(Any revisions or follow-up required by the HRC for approval of the plan/ protocol)

By signing below, HRC confirms decision of the Committee Members (or designees).

(Sign and date)

Guardian/ Individual Approval Signature: Plan/ Protocol cannot be implemented until guardian signature is obtained Date: (Month/ Day/ Year)