***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)