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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-00926 (02/2022) | | | | | | | | | |  | | | | | | | | | | **STATE OF WISCONSIN**  Wis. Stat. § 51.61(1)(i)  Wis. Admin. Code ch. DHS 94.10 | | | | | | | | | | | | | | |
| **APPLICATION FOR THE USE OF PROTECTIVE EQUIPMENT OR MECHANICAL RESTRAINT**  **CLTS AND CCOP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This form must be completed to request approval for the use of protective equipment or mechanical restraints for participants in the Children’s Long-Term Support (CLTS) Program or Children’s Community Options Program (CCOP). Personally Identifiable Information is collected on this form for the sole purpose of identifying the waiver participant and processing the request, and will not be used for any other purpose. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name — Participant | | | | | | | | | | | | | | | Date of Birth | | | | | | | | | Type of Request  New  Review | | | | | | | | | | |
| Current Address — Participant | | | | | | | | | | | | | | | City | | | | | | | | | | | State | | | | | Zip Code | | | |
| Participant’s Applicable Target Group(s) (check all that apply):  CLTS—DD  CLTS—PD  CLTS—MH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name — Parent/Guardian | | | | | | | | | | | | | | | | | | | | | | Phone — Parent/Guardian | | | | | | | | | | | | |
| Current Residence — Participant  Personal/Family Residence *(Same address as above)*  Licensed or Certified Facility, e.g., Adult Family Home, Foster Home, Level 5 Foster Home *(Provide name and address below.)*  Other *(Describe and provide address below.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Residence Street Address (if different from above) | | | | | | | | | | | | | | | | | | City | | | | | | | | | | State | | | | | Zip Code | |
| 1) Name — Provider/ Agency that will use the restrictive measure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service Type | | | | | | | | | | | | | | Service Frequency | | | | | | | | | | | | | | | | | | | | |
| Address — Provider/Agency | | | | | | | | | | | | | | | | | | | | | | | | Phone | | | | | | | | | | |
| City | | | | | | | | | | | State | | | | | Zip Code | | | | | | | | Fax Number | | | | | | | | | | |
| Email | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2) Name — Provider/ Agency that will use the restrictive measure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service Type and Frequency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address — Provider/Agency | | | | | | | | | | | | | | | | | | | | | | | | Phone | | | | | | | | | | |
| City | | | | | | | | | | | State | | | | | Zip Code | | | | | | | | Fax Number | | | | | | | | | | |
| Email | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| County Waiver Agency Submitting This Request | | | | | | | | | | | | | | | | | | | | | | | | Date Submitted | | | | | | | | | | |
| Contact Person/Support & Service Coordinator | | | | | | | | | Phone | | | | | | | | Fax Number | | | | Email | | | | | | | | | | | | | |
| Address — County Waiver Agency | | | | | | | | | | | | | | | | | City | | | | | | | | | | State | | | | | Zip Code | | |
| **Definitions** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Check “Yes” or “No,” if the following apply. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Yes** | | **No** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | **Protective Equipment** | | | | | Protective equipment includes devices that do not restrict movement but do limit access to one’s body and are applied to any part of a child or youth’s body for the purpose of preventing tissue damage or other physical harm that may result from their behavior. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | **Mechanical Restraints** | | | | | The use of a device within the environment or applied to any part of a child or youth’s body that restricts or prevents voluntary movement within the environment or normal use or functioning of the body or body part that cannot be easily removed by the child or youth and is above and beyond typical safety measures used for same aged peers. | | | | | | | | | | | | | | | | | | | | | | | | | |
| If the answer to any of the above definitions is “**Yes**,” continue. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Personal Summary** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Daytime Activity/ School Program | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Support Systems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interests | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dislikes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Health Considerations** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnoses | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Health Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height:       Weight: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication** | | | | | | **Dose** | | | | | | | | **Purpose** | | | | | | | | | | | **Prescribing Physician** | | | | | | | | |
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| **Health Providers** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Specialty** | | | | | **Name** | | | | | | | | **Address** | | | | | | | | | | | | | | | | **Phone** | | | | |
| Primary Physician | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| Psychiatrist | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| Psychologist / Therapist | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| Neurologist | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| Other | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| Other | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | |
| **Target Behavior**  *Please attach copy of current support plan or behavior support plan* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach the person’s dangerous behaviors and the situations in which they occur. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Describe or attach the frequency and intensity of the above behaviors. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Describe or attach the patterns that have been observed when the behavior occurs, i.e., what triggers the behavior. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach the plan currently being done proactively to prevent these behaviors from occurring. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Previous Support Strategies or Interventions** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List and explain or attach previous support strategies or interventions, when they were tried, how long they were tried, and the outcomes. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. | Support Strategy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Outcome | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. | Support Strategy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Outcome | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 3. | Support Strategy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Outcome | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 4. | Support Strategy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Outcome | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Current and Proposed Strategies** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach the current and proposed strategies and safeguards for target behaviors. Include positive behavior supports and prevention plans, level of supervision, or other environmental modifications. Attach the current support plan, OT and PT evaluations, physician orders, informed consent by the participant or guardian. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **What is the need?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Explain or attach why the current strategies are ineffective. Describe what more is needed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Risks and Benefits** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe a risk and benefit analysis for the use of the protective equipment or mechanical restraint. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Proposed Protective Equipment or Mechanical Restraint** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Identify proposed procedure or device and why these strategies are needed.  **Attach relevant photos, manufacturer specifications, or literature.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Procedure / Device** | | | | **Purpose** | | | | | | | | **Plan**  *(Specify where procedure or device used, when, length of time, etc.)* | | | | | | | | | | | **Desired Outcome** | | | | | | | | | | |
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| **Physician Orders** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Include written authorization by a physician, identifying the type of item ordered, the indication for its use, the time period for its application, and any potential considerations for the use of the proposed restrictive measure. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Intervention Plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach the sequential process during which less restrictive measures will be used that precedes the use of protective equipment or mechanical restraint. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Training** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach the plan to provide initial and on-going training for staff. Identify who will conduct the training, their credentials, the duration of training, and how the training will be documented. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Reduction and Elimination Plan for the Use of Protective Equipment or Mechanical Restraint** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach the plan for reducing and eventually eliminating the need for protective equipment or mechanical restraint. Include measurable benchmarks. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Support Plan Monitoring and Review of Approved Protective Equipment or Mechanical Restraint Usage** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe or attach how the support plan and approved measure usage will be monitored, documented, and reviewed. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Individuals Having Input Into the Support Plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | | | | | | | **Relationship to Participant** | | | | | | | | | | | | | | | | |
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| **Plan Review** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Plan Reviewed By** | | | | | | | **Name** | | | | | | | | | | | | **Signature** | | | | | | | | | | | **Date Reviewed** | | | |
| Parent /Participant (if over age 18 and not under guardianship\*) | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Guardian, if applicable\* | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Placing Agency\* | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Provider Agency\* | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Primary Physician\*\* | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Behavior Consultant or Specialist | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Other | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |
| Other | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | |  | | | |

\* Required signatures

\*\*Required signature unless signed doctor’s order, prescription, or letter of support is included with application