

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

Individual's Name: _____ Duck #: _____

Provider Agency(s): _____ Guardian: _____

Date of Plan Submission: _____ Date of Plan: _____

Reason for Submission:

- | | |
|---|--|
| <input type="checkbox"/> New Plan/ Protocol | <input type="checkbox"/> Annual Re-Approval with changes (must highlight changes) |
| <input type="checkbox"/> Emergency/Interim Plan/ Protocol | <input type="checkbox"/> Annual Re-Approval without changes |
| <input type="checkbox"/> Current Plan/ Protocol Extension Request | <input type="checkbox"/> Plan/ Protocol Termination |
| <input type="checkbox"/> Current Plan/ Protocol Revision | <input type="checkbox"/> PRN Protocol |

Current Submission packet includes:

- | | |
|--|--|
| <input type="checkbox"/> Current Plan/ Protocol | <input type="checkbox"/> Summary & Analysis of Current Data for Review |
| <input type="checkbox"/> Blank Data Collection Sheet (if applicable) | <input type="checkbox"/> Current Medication List |
| <input type="checkbox"/> House Policies (if applicable) | <input type="checkbox"/> Psychotropic PRN Protocol |
| <input type="checkbox"/> START/ Risk/ Mental Health Plan (if applicable) | <input type="checkbox"/> Psychotropic PRN Medication Order (if applicable) |

Restrictive Procedures (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Physical Intervention | <input type="checkbox"/> Mechanical Intervention/ Adaptive Equipment |
| <input type="checkbox"/> Chemical (PRN) Intervention | <input type="checkbox"/> Environmental Restrictions |
| <input type="checkbox"/> Use of Protective Clothing/equipment | <input type="checkbox"/> Other: _____ |

Summary of Circumstances:

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: _____ Date: _____

Printed Name: _____ Email Address: _____ Phone: _____

Program Administrator Signature: _____ Date: _____

Printed Name: _____ Email Address: _____ Phone: _____

Program Administrator Signature: _____ Date: _____

Printed Name: _____ Email Address: _____ Phone: _____

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: _____ Printed Name: _____ Date: _____

Individual's Name/Duck #: _____ Level: 1 2 3 N/A

HRC Decision:

- Emergency Approval Until Next Available HRC Meeting
Approval Begins: _____ Approval Expires: _____
- Temporary Approval With Follow Up Needed (See HRC comments and Provider Follow-up Required)
Approval Begins: _____ Approval Expires: _____
- Full Approval
Approval Begins: _____ Approval Expires: _____
- Plan Termination Approved- Date: _____
- Not Approved- Date: _____
Reason: _____

HRC Comments:

Provider Agency Follow-up Required:

Current Medication List Needed Current Plan Needed Blank Data Collection Sheet Needed
 Termination Criteria Needed HRC Approval Request Cover Sheet Needed
 Other Follow-up Needed- Describe Below:

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

Guardian/ Individual Approval Signature: _____ Date: _____