Instructions

Updated: 9/2023

Purpose

Form 6501 is used by the Deaf Blind with Multiple Disabilities (DBMD) program to:

- document the results of a person centered planning discovery process;
- record the individual's natural supports and non-waiver services, as well as document that DBMD services do not replace the natural supports or non-waiver resources;
- document the needs and preferences identified by the individual;
- determine whether the individual needs a service backup plan;
- determine the outcomes to be achieved through the DBMD program services and goals that will be used to reach these outcomes; and
- justify each service and the frequency or duration of each required service category on Form 6500, Individual Plan of Care (IPC)-DBMD.

Procedure

When to Prepare

The case manager must complete an Individual Program Plan (IPP) for enrollment, renewal and revision of the Individual Service Plan (ISP) or IPC in accordance with the guidelines established in Title 26 of the Texas Administrative Code (TAC), Part 1, Chapter 260.

Form Retention and Transmittal

The case manager files the completed, signed and dated Form 6501 in the applicant's or individual's case record.

The case manager submits a copy of the completed Form 6501 to Texas Health and Human Services Commission along with the enrollment IPCs, IPC revisions and IPC renewals.

The case manager must submit the completed, signed and dated Form 6501 via the IDD Operations Portal (preferred), or mail or fax to the following address:

Texas Health and Human Services Commission
DBMD Waiver Program, Mail Code W-521
P. O. Box 149030
Austin, TX 78714-9030

Fax Number: 512-438-5135

Detailed Instructions

Program Provider's Name: -- Enter the DBMD provider agency name.

1. General Information

Individual -- Enter the individual's name in the space provided on Page 1 and at the top of each page. This is helpful if the pages get separated. Note: In the electronic version, the name in this blank will auto-populate in the name blanks throughout the document.

Date of Enrollment -- Enter the date the individual was enrolled into the DBMD program.

Date of Team Meeting -- Enter the date of the SPT meeting.

Date of Birth -- Enter the individual's date of birth.

Social Security No. -- Enter the individual's Social Security number.

Individual Plan of Care (IPC) Effective Period -- Enter the IPC effective period as it appears on the individual's IPC (Form 6500).

Medicaid Number -- Enter the individual's nine-digit Medicaid number.

Medicare Number -- Enter the individual's nine-digit Medicare number, if applicable.

Employment Status -- Mark the appropriate box to indicate the individual's employment status.

Education Level -- Mark the appropriate box to indicate the individual's education level:

- Education Level:

- Less than high school (HS)
- HS diploma or equivalence
- Some College
- College degree
- Masters or higher
- Other, with entry field to specify other educational level

2. Service Planning Team (SPT) Members Present

Enter the names of the individuals present at the SPT meeting in the corresponding space provided.

3. Individual's Profile

The format of this One-Page Profile is based on work by The Learning Community for Person Centered Practices.

_____***'s One-Page Profile*** -- Enter the individual's name unless auto-populated.

Insert Photo Here (optional) -- If possible, insert one or two recent photos of the individual or photos of people, places or things that are important to the individual, if available. This is optional but provides additional information about the individual.

A little about myself -- Provide general information about the individual based on information gathered through a person centered planning style discovery process.

What people like and admire about me -- Enter a descriptive narrative including what you have learned through the discovery process that others like and admire about the individual. This question is designed to help the individual identify his or her strengths.

What's important to me -- Enter what you have learned through the discovery process that is important to the individual. “Important to” reflects what is important from the individual’s perspective and is based on the conversation with the individual. The information might include important relationships, how the individual prefers to interact, things the individual likes to do or not do, preferred routines, relevant background information that may affect how the service should be delivered and what the individual wants to do in the future. Remember the individual’s response is limited to the knowledge

and experiences he or she has to date. Additional efforts should be explored to increase his or her awareness of additional possibilities and experiences to increase his or her options of choice.

What others need to know and do to support me -- Enter important information you have learned through the discovery process about the individual, such as how the individual communicates and how to best communicate with him or her. Include what you have learned through the discovery process that is important for the individual, as identified by those who know him or her best. “Important for” reflects information that is important for the service provider to know and understand about the individual. This information should be related to health, safety and any supports regarded as necessary to enhance the individual to be a valued member of the community. Enter information such as health needs, supervision requirements, specific behavioral needs and special instructions for those who support the individual. This section includes contraindications and special justifications for deviating from typical routines or activities.

This section can identify a non-waiver service that is supported by a desired waiver service. For example, transportation provided through another service may be necessary for the individual’s supported employment activities. List any barriers that could prevent the outcomes or purposes from being achieved. Things identified as “important for” are not usually included as “important to” the individual.

What the people are like that support me best -- Enter important information you have learned through the discovery process about the individual, such as the types and characteristics (for example, gentle voice, patient, enjoys doing the same things) of people who support the individual well. Provide any information that may be important to a successful match between the individual and the residential habilitation provider. You may also include types and characteristics of people that don’t support the individual well.

How I like to spend my day -- Enter important information you have learned through the discovery process about the individual such as what the individual enjoys doing during the day and important routines or rituals for the individual. Indicate if the individual enjoys being in the community, staying home, being with large groups or being alone.

The services I am currently receiving are -- Enter important information you have learned through the discovery process about the individual current

services, both professional and non-professional. This may include therapies, waiver and non-waiver supports.

4. Important People in the Individual's Life

People in_____'s Life -- Enter the individual's name unless auto-populated.

List the people who are close to the individual and who know and care about the individual in the appropriate category: family, friends, school, work or other, or community or other. Professionals working with the individual, such as doctors or therapists, can be listed in the community or other category. This will help the provider in determining who to speak with in certain situations. It will also help to ensure that the individual does not lose contact with important people in his or her life. Additional rows may be added, if necessary. Enter the names, relationships, phone numbers, addresses, email addresses and the reason the individual or LAR has identified this person as being important to list on this form. Examples of "important because" are:

- He takes the individual to work.
- She is a friend the individual calls every weekend.
- He stays with the individual until mom comes home from work.
- She is the individual's favorite teacher and helps tutor on weekends.
- He takes the individual to Special Olympics practices and out to eat.
- The individual stays with him during the holidays.

5. Financial Resources

Source(s) of Income -- Indicate the source(s) of the individual's income (for example, Supplemental Security Income (SSI) or employment).

Monthly Amount -- Enter the monthly amount of income for the individual.

Trust Fund -- Indicate if the individual has a trust fund. Document the amount in the trust fund, if known.

Other Financial Resources -- Indicate the amount of other financial resources the individual has.

Room and Board **(Assisted Living Facility (ALF) only)** -- Indicate the amount the individual pays in room and board if the individual is living in a DBMD ALF or mark NA.

Representative Payee -- Indicate the individual's representative payee or mark NA.

Additional Information -- Provide any other relevant financial information.

Describe the individual's money management skills -- Explain how the individual manages money, if he or she requires assistance, who provides that assistance and what type of assistance he or she requires to manage his or her money.

6. Emergency Contact(s)

Indicate each of the individual's emergency contact(s). Provide the person's name and relationship to the individual (i.e., parent, guardian, neighbor). Provide the contact information, including address, area code and phone number, an alternate phone number and email, if available.

7. Diagnoses

Indicate the individual's diagnoses, the diagnostic code, the source (name and title of the professional who diagnosed the individual) and the date of onset of the diagnosis. Note: Be sure to include the diagnoses which qualified the individual for the DBMD program, as well as any other diagnoses related to the services as reflected on the Nursing Assessment. Additional rows may be added, or an addendum can be attached, as needed.

8. Legal Status

Mark one of the boxes indicating the individual is:

- an adult with an LAR (e.g., court appointed guardian or power of attorney) and if marked, enter the LAR's name in the space provided;
- an adult with no LAR; or
- other (e.g., minor) and specify.

Indicate Yes or No if there is a current copy of guardianship papers on file. If No is marked and a special circumstance exists, explain in the space provided. If the individual is an adult and there are no current guardianship papers available, the individual must sign or provide his or her mark on all official documents.

9. Freedom of Choice

Complete this section to document that the Freedom of Choice form was presented to the individual or his or her LAR. Provide the person's name in the space provided (all alternatives to the DBMD waiver should be discussed and all boxes should be marked, as well as the final box documenting that the individual or LAR was given the Provider Choice form and the agency the individual or LAR selected in the space provided).

10. Consumer Directed Services (CDS)

Document that the CDS option was presented to the individual or LAR. Mark the appropriate box to indicate the CDS or provider agency option.

Additional Information -- Document the CDS forms provided to the individual and any other related information to the individual's CDS or provider agency choice.

11. Individual's Rights

Mark the box to document that the case manager provided a copy of the Consumer Rights Booklet to the individual and took the opportunity to discuss the individual's rights during the SPT.

Additional Information -- Provide any additional information related to the individual's rights.

12. Communication

Mark all that apply to indicate the forms of communication that the individual engages in: gestures, pictures, calendar, sign language, verbal communication or other.

Mark Yes or No to indicate if the individual uses behaviors to communicate. If yes, explain what behaviors the individual uses to communicate and the meanings of these behaviors if you know them.

How does service provider communicate with the individual? -- Describe the methods the service provider uses to communicate with the individual (i.e., pictures symbols, calendars, items, tactile sign, etc.).

What is in place to assist the individual in communicating effectively? -- Describe ways to assist the individual, such as communication calendars, picture books or a communication device like a Dynavox.

Additional information about the individual's communication -- Provide any other related information about how the individual communicates.

13. Behaviors

List the individual's most significant challenging behaviors and triggers -- Document the individual's challenging behaviors, if any. Provide any information regarding events that are known preceding challenging behaviors.

What measures are in place to prevent challenging behaviors? -- List any strategies or measures used to prevent challenging behaviors (i.e., restraints, communication, behavior support techniques or strategies, specific routines, etc.). Ensure any restraints are used in line with TAC Section 260.217, Restraints.

Is there a behavior support plan in place? -- Mark Yes or No. If yes, provide the name and title of the professional responsible for the design and implementation of the behavior support plan.

Additional information -- Provide any other related information regarding the individual's behavior.

14 Living Arrangement

Mark the appropriate box to indicate what setting the individual resides in:

- own home family home;
- ALF 4 to 6 bed;
- licensed home health assisted living (3 or less); or
- other, (specify).

Document any safety concerns and measures in place to ensure the individual's safety.

Is this the individual's preferred living arrangement? -- Mark Yes or No to indicate if this is the individual's preferred living arrangement (i.e., group home, apartment, own home family home, etc.). If no, explain the individual's preferred living arrangement. This should be based on the information gathered through a person centered planning process regarding what is important to and for the individual. If he or she is not living in his or her preferred living arrangement, are there steps being taken to assist him or her

to live in the preferred living arrangement? Is this an outcome the individual is working toward?

What does the individual like about this living arrangement? -- Document what the individual likes about his or her current living arrangement and what is working for the individual in this living arrangement.

What does the individual dislike about this living arrangement? -- Document what the individual dislikes about the current living arrangement and what is not working for the individual in this situation.

Additional Information -- Provide any other information related to this section.

15. Activities of Daily Living or Instrumental Activities of Daily Living

Mark the appropriate box to indicate the level of assistance required for each activity listed: independent, needs assistance, or dependent. Provide comments, as necessary, to further explain the individual's abilities and needs (i.e., requires prompting only, will not allow staff to assist, etc.).

- Independent -- The individual can complete this task on his own. He may require prompting or supervision but no hands-on assistance.
- Needs Assistance -- The individual can provide some assistance in completing the task. The task may be completed with hand over hand or part may be done for the individual and the other part done by the individual.
- Dependent -- The individual is not able to assist at all in completing the task; it must be done for the individual.

Mark the box in the Habilitation Training column to indicate if the individual needs habilitation or training in that activity.

Habilitation Activities

Mark the box in the Habilitation Training column to indicate if the individual needs habilitation or training in that activity. Provide comments, as necessary, to further explain the individual's abilities and needs.

Additional Information -- Provide any other related information to the individual's activities of daily living and functional abilities.

16. School Schedule

Provide the individual's school schedule, if applicable, or mark Not applicable. For school age individuals, indicate what type of schooling the individual attends (i.e., college, high school, home school) or what type of activities are completed at the school (therapies, math, work program) under the Activities column.

Provide a start time and end time for each activity under each day of the week. Provide a total number of hours for each activity for the week in the Total Hours column. Then, provide a weekly total number of hours for school.

17. Personal Care Services

Provide the individual's personal care services schedule, if applicable, or mark Not applicable. Indicate what type of activities the individual receives assistance with under the Activities column (i.e., bathing, dressing, meal preparation). Provide a start time and end time for each activity under each day of the week. Provide a total number of hours for each activity for the week in the Total Hours column. Then, provide a weekly total number of hours for personal care services.

18. Orientation and Mobility

The answers in this section help provide a picture of the individual's ability to navigate his or her environment. These questions will identify if the individual has needs that could be addressed through orientation and mobility services.

Mark the appropriate box to indicate how the individual accesses the home: independently, with assistance or with specialized adaptive equipment. If with specialized equipment is marked, specify what type of adaptive equipment is needed.

Mark Yes or No to indicate if the individual needs to be re-oriented to the home after furniture is moved.

Mark Yes or No to indicate if there are landmarks to assist the individual within the home. If yes, mark the appropriate box to indicate if those landmarks are appropriate or inappropriate to assist the individual within the home.

Mark the appropriate box to indicate how the individual accesses the community: independently, with assistance or with specialized adaptive

equipment. If with specialized equipment is marked, specify what type of adaptive equipment is needed.

Mark Yes or No to indicate if the individual can move safely within the neighborhood or immediate community.

Mark Yes or No to indicate if the individual can safely access public transportation.

Mark the appropriate box to indicate if there are any recent significant changes (i.e., a move, a new roommate, etc.) to the individual's environment. If yes, describe in additional information.

Additional Information -- Provide any other related information to the individual's orientation and mobility.

19. Community First Choice Services

CFC PAS/HAB (Svc code 10CFC)

Complete the information if the individual is requesting CFC PAS/HAB. If the individual is receiving service codes 19,19E or 19F, or if the individual does not require CFC PAS/HAB services, mark Not applicable and leave this box blank.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Services to be provided by -- Indicate the primary service provider in the first blank and provide any other service providers that may be utilized.

Fill in the space with the number of hours requested for each week and the number of weeks requested.

Multiply to get the total requested for that schedule. If there is only one schedule, the total will be the same as the amount on the IPC.

If there are two schedules (i.e., in-school and out-of-school schedules), provide the second schedule hours in the same format and document the reason for multiple schedules in the Justification for units.

Mark Yes or No to indicate if this service is being provided through the CDS option.

Mark Yes or No to indicate if the SPT has determined this service to be critical to the individual's health and safety. If marked yes, Form 3628, Provider Agency Model Service Backup Plan, or if utilizing CDS, Form 1740, Service Backup Plan, must be completed.

Justification for units -- Provide justification for CFC PAS/HAB based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC.

Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

Note: A service provider must not be the parent of an individual if the individual is under 18 years old. The parent of a child is considered the legally responsible adult and, as such, care provided to the child is a natural support that cannot be replaced by a waiver service.

If the hours requested have increased from the previous IPC year, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

CFC PAS/HAB Schedule 1 -- Provide the individual's CFC PAS/HAB services schedule. Specify the type of schedule (i.e., in-school and out- of-school schedules) in the space provided if more than one schedule is needed. Indicate what type of activities the individual receives assistance with under the Activities column (i.e., bathing, dressing, meal preparation). Provide a start time and end time for each activity under each day of the week. Provide a total number of hours for each activity for the week in the Total Hours column. Then, provide a weekly total number of hours for residential habilitation.

CFC PAS/HAB Schedule 2 -- If there are two schedules, provide the second schedule in the same format as Schedule 1. Specify the type of schedule (i.e., in-school and out-of-school schedules) in the space provided. If there is not a second schedule, mark Not applicable.

Support Management

Mark yes or no to indicate if the individual would like to receive support management.

CFC Emergency Response Services

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Justification for units -- Provide justification detailing the need for CFC emergency response services based on the requirements listed in TAC 260.359.

CFC Financial Management Services-- Complete if the individual is requesting CFC Financial Management Services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the Financial Management Agency that will be utilized for this service.

Support Consultation -- Complete if the individual is requesting support consultation services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Justification for units -- Provide justification detailing the need for support consultation services. Provide detailed information regarding the support consultation activities that will be provided, and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC Form 6500 must be the same.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service. Indicate any preferences or special considerations identified during the discovery process or the completion of this tool. This could include the individual prefers to take baths over showers, or factors such as behaviors which result in higher support needs.

20. Justification for DBMD Services

Note: On the electronic form, sections will collapse when the Not applicable box is marked. To expand the section, un-mark the Not applicable box.

All information provided in this section should be developed by the SPT and based on the preferences of the individual.

Complete each box in its entirety. Unless a question within a section provides a "not applicable" option, the information is required for authorization of that service. If you are unsure what information is required for a particular section, access the TAC reference provided for that section.

If an individual's schedule varies for a particular service, provide a typical schedule or as much information as possible regarding when the services are provided.

Justifications for services can only be billable activities. Outcome based goals must be provided for each service as well as documentation of the attempt to access non-waiver services. Most services also require a specific breakdown of the activities that will be completed through that service and the hours, units and dollars that will be required for completion of that activity or service.

1(A). Case Management (Service Code 12)

Complete the information if the individual is requesting case management. If the individual does not require case management services, mark Not applicable and leave this section blank.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate who will provide the service. Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Justification for the units -- Provide justification for case management based on the requirements listed in TAC Section 260.67 (b) (1-6), Development of a Proposed Enrollment IPC, as well as TAC Section 260.337, Case Management. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

If the hours requested have increased from the previous IPC, what has changed to cause the increase? -- Document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

1(B). Case Management (Service Code 12D)

Complete the information if the individual is requesting case management. If the individual does not require case management services, mark Not applicable and leave this section blank.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate who will provide the service. Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Justification for the units -- Provide justification for case management based on the requirements listed in TAC Section 260.67 (b) (1-6), Development of a Proposed Enrollment IPC, as well as TAC Section 260.337, Case Management. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

If the hours requested have increased from the previous IPC, what has changed to cause the increase? -- Document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

2. In-Home Respite (Service Code 11)

Complete the information if the individual is requesting in-home respite. If the individual is receiving service codes 19,19E or 19F, or if the individual does not require in-home respite services, mark Not applicable and leave this box blank.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Services to be provided by -- Indicate the primary service provider in the first blank and then provide the name of any additional respite service providers, if applicable. If more than two respite service providers exist, each can be listed on a separate page as an attachment.

Mark Yes or No to indicate if this service is being provided through the CDS option.

Justification for units -- Provide justification for in-home respite based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.353, Respite. Provide detailed information regarding the need for the specific units requested of this service. The total number of units justified here and the number of units on the

IPC (Form 6500) must be the same. The combined total of in-home respite and out-of-home respite cannot exceed 30 units.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

3. Out-of-Home Respite (Service Code 11A)

Complete the information if the individual is requesting out-of-home respite. If the individual is receiving service codes 19,19E or 19F, or if the individual does not require out-of-home respite services, mark Not applicable and leave this box blank.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Services will be provided at -- Document where the out-of-home services will be provided. If the individual or LAR does not know, write "unknown" in the space provided. Provide the name of any additional respite service providers, if applicable. If more than two respite service providers exist, each can be listed on a separate page as an attachment.

Mark Yes or No to indicate if this service is being provided through the CDS option.

Justification for units -- Provide justification for out-of-home respite based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.353, Respite. Provide detailed information regarding the need for the specific units requested of this service. The total number of units justified here and the number of units on the IPC (Form 6500) must be the same. The combined total of in-home respite and out-of-home respite cannot exceed 30 units.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

4. Residential Habilitation (Service Code 17)

Complete the information if the individual is requesting residential habilitation. If the individual is receiving service codes 19,19E or 19F, or if the individual does not require residential habilitation services, mark Not applicable and leave this box blank.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Services to be provided by -- Indicate the primary service provider in the first blank and provide any other service providers that may be utilized.

Fill in the space with the number of hours requested for each week and the number of weeks requested.

Multiply to get the total requested for that schedule. If there is only one schedule, the total will be the same as the amount on the IPC.

If there are two schedules (i.e., in-school and out-of-school schedules), provide the second schedule hours in the same format and document the reason for multiple schedules in the Justification for units.

Mark Yes or No to indicate if this service is being provided through the CDS option.

Mark Yes or No to indicate if the SPT has determined this service to be critical to the individual's health and safety. If marked yes, Form 3628, Provider Agency Model Service Backup Plan, or if utilizing CDS, Form 1740, Service Backup Plan must be completed.

Justification for units -- Provide justification for residential habilitation based on the requirements listed in TAC Section 260.67(b)(1-6), Development of a Proposed Enrollment IPC, and Section 260.343, Habilitation.

Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

Note: A service provider must not be the parent of an individual if the individual is under 18 years old. The parent of a child is considered the legally responsible adult and, as such, care provided to the child is a natural support that cannot be replaced by a waiver service.

If the hours requested have increased from the previous IPC year, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Residential Habilitation Schedule 1 -- Provide the individual's residential habilitation services schedule. Specify the type of schedule (i.e., in-school and out- of-school schedules) in the space provided if more than one schedule is needed. Indicate what type of activities the individual receives assistance with under the Activities column (i.e., bathing, dressing, meal preparation). Provide a start time and end time for each activity under each day of the week. Provide a total number of hours for each activity for the week in the Total Hours column. Then, provide a weekly total number of hours for residential habilitation.

Residential Habilitation Schedule 2 -- If there are two schedules, provide the second schedule in the same format as Schedule 1. Specify the type of schedule (i.e., in-school and out-of-school schedules) in the space provided. If there is not a second schedule, mark Not applicable.

5. Skilled Nursing Services

Mark the appropriate box to indicate what type(s) of skilled nursing the individual is requesting: Registered Nurse (RN, Service Code 13B), Licensed Vocational Nurse (LVN, Service Code 13A), or mark Not applicable.

Mark the box to indicate you have attached the current nursing assessment.

Total RN units -- Fill in the space with the total number of units for the RN service category as listed on the IPC (Form 6500), if applicable, and nursing assessment.

Services to be provided by -- Indicate the primary RN service provider in the space provided.

Fill in the space with the total number of units of RN service category utilized in the previous IPC year.

Mark the appropriate box to indicate if the SPT has determined this service to be critical to the individual's health and safety. If marked yes, Form 3628, Provider Agency Model Service Backup Plan, or if utilizing CDS, Form 1740, Service Backup Plan, must be completed.

Total LVN units -- Fill in the space with the total number of units for the LVN service category, as listed on the IPC (Form 6500), if applicable, and nursing assessment.

Services to be provided by -- Indicate the primary LVN service provider in the space provided.

Fill in the space with the total number of units of LVN service category utilized in the previous IPC year.

Mark Yes or No to indicate if the SPT has determined this service to be critical to the individual's health and safety. If marked yes, Form 3628, or if utilizing CDS, Form 1740, must be completed.

Justification for RN units -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.347, Nursing.

Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This breakdown should total the same number of units as requested on the IPC Form 6500.

Justification for LVN units -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6) and TAC Section 260.347. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This breakdown should total the same number of units as requested on the IPC (Form 6500).

If the hours requested for RN or LVN have increased from the previous IPC, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

6. Specialized Nursing

Mark the appropriate box to indicate what type(s) of specialized nursing the individual is requesting: Registered Nurse (RN, Service Code 13C), Licensed Vocational Nurse (LVN, Service Code 13D), or Not applicable.

Fill in the space with the total number of units for the Specialized RN service category as listed on the IPC (Form 6500), if applicable, and the nursing assessment.

Services to be provided by -- Indicate the primary RN service provider in the space provided.

Fill in the space with the total number of units of Specialized RN service category utilized in the previous IPC year.

Mark the appropriate box to indicate if the SPT has determined this service to be critical to the individual's health and safety. If marked yes, Form 3628, Provider Agency Model Service Backup Plan, or if utilizing CDS, Form 1740, Service Backup Plan, must be completed.

Fill in the space with the total number of units for the Specialized LVN service category as listed on the IPC (Form 6500), if applicable, and the nursing assessment.

Services to be provided by -- Indicate the primary LVN service provider in the space provided.

Fill in the space with the total number of units of Specialized LVN service category utilized in the previous IPC year.

Mark Yes or No if the SPT has determined this service to be critical to the individual's health and safety. If marked yes, Form 3628, Provider Agency Model Service Backup Plan, or if utilizing CDS, Form 1740, Service Backup Plan, must be completed.

Mark Yes or No to indicate if the individual uses a ventilator at least six hours per day or requires tracheostomy care at least once per day. If no, the individual does not qualify for specialized nursing.

Mark Yes or No to indicate if HHSC has authorized the Specialized Nursing Certification Form (authorization is required prior to provision of this service).

Justification for specialized RN units -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.347, Nursing. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Be sure to indicate why specialized RN units are needed rather than standard RN units. Use this breakdown to determine the number of units needed on the IPC. This breakdown should total the same number of units as requested on the IPC (Form 6500).

Justification for specialized LVN units -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6) and TAC Section 260.347. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Be sure to indicate why specialized LVN units are needed rather than standard LVN units. Use this breakdown to determine the number of units needed on the IPC. This breakdown should total the same number of units as requested on the IPC (Form 6500).

If the hours requested have increased from the previous IPC, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

7. Day Habilitation (Service Code 10)

Complete if the individual is requesting day habilitation or mark Not applicable.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Services to be provided by -- Document the name of the day habilitation center that will be utilized for this service.

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Fill in the space with the number of hours requested for each week and the number of weeks requested and the total requested for that schedule.

Document the service provider to individual ratio (number of service providers per number of individuals). Any ratio less than 1:1 must be documented in the justification in line with TAC Section 260.343, Habilitation (a) (2-3).

Justification for units -- Provide justification for day habilitation services based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.343, Habilitation. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

If the hours requested have increased from the previous IPC, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Day Habilitation Schedule -- Provide the individual's day habilitation services schedule, if applicable. Indicate the staff name who will assist the individual in the first column. Provide a start time and end time for each activity under each day of the week. Provide a total number of hours for each activity for the week in Total Hours column. Then, provide a weekly total number of hours for day habilitation.

8. Individualized Skills and Socialization (Service Code 23)

Complete if the individual is requesting individualized skills and socialization or mark Not applicable.

Fill in the space with the total number of units for both on-site and off-site for this service category as listed on the IPC (Form 6500).

Services to be provided by -- Document the name of the individualized skills and socialization center that will be utilized for this service.

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Fill in the space with the number of hours requested for each week and the number of weeks requested and the total requested for that schedule.

Document the service provider to individual ratio (number of service providers per number of individuals). Any ratio less than 1:1 must be documented in the justification in line with TAC Section 260.507, Staffing Ratios.

Justification for units -- Provide justification for individualized skills and socialization services based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.511, Including Individualized Skills and Socialization on an IPC. Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

If the hours requested have increased from the previous IPC, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Does the individual want to receive on-site or off-site individualized skills and socialization but not both? – If the individual does not want to receive both on-site and off-site individualized skills and socialization, document whether the individual would like to receive either only on-site individualized skills and socialization or only off-site individualized skills and socialization. Rationale for selection must be completed in accordance with the preferences of the individual for on-site and off-site.

Individualized Skills and Socialization Schedule -- Provide the individual's individualized skills and socialization services schedule, if applicable. Provide a start time and end time for each activity under each day of the week in the correct on-site or off-site row. Provide a total number of hours for each activity for the week in Total Hours column. Then, provide a weekly total number of hours for individualized skills and socialization.

9. Minor Home Modifications (MHM) (Service Code 16)

Complete if the individual is requesting minor home modifications or mark Not applicable.

Note: Form 6507, Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications, must be submitted with all adaptive aid and medical supplies requests. Per TAC Section 260.313, Items or Services Purchasable as a Minor Home Modification, a program provider may not purchase, as a minor home modification, an item or service not listed in the *Deaf Blind with Multiple Disabilities (DBMD) Provider Manual.*

Fill in the space with the total dollar amount for minor home modifications, as listed on the IPC (Form 6500).

Fill in the space with the total dollar amount for minor home modifications Requisition Fee as listed on the IPC (Form 6500), as identified in the Health and Human Services Commission (HHSC) DBMD Program Payment Rates.

Services to be provided by -- Indicate the service provider utilized for this service.

Professional recommending MHM -- Indicate the appropriate licensed professional (name and title) who recommended the MHM. Ensure this professional is licensed in one of the areas listed in Section 2000, Minor Home Modification Services, of the *DBMD Provider Manual*.

List of MHM(s) requested -- List the MHM(s) that are requested and include the amount for each item in the space on the right side of the page. If additional space is needed, this section can be expanded, or an addendum can be attached. Each MHM should be listed separately with a distinct price.

Justification for units -- Provide justification for each MHM based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.315-Section 260.331 regarding minor home modifications.

Fill in the space with the MHM(s) that the individual has had completed up to this point using waiver funds.

Fill in the space with the total dollar amount utilized for MHM modifications since the individual's enrollment in the DBMD program. **Note**: The lifetime cap is $10,000. If a request exceeds the lifetime cap or is not included on the HHSC approved list, the MHM is denied by the HHSC program specialist, and the individual is given the right to a fair hearing.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

10. Chore Services (Service Code 17E)

Complete if the individual is requesting chore services or mark Not applicable.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Justification for units -- Provide justification for chore services based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.335, Chore Services. Provide detailed information regarding the chore activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

If the hours requested have increased from the previous IPC, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Chore Services Schedule -- Provide the individual's chore services schedule, if applicable. Indicate the service provider who will assist the individual with chore services in the first column. Provide a start time and end time for each service provider under each day of the week. Provide a total number of hours for each service provider member for the week in the Total Hours column. Then, provide a weekly total number of hours for chore services.

11. Adaptive Aids and Medical Supplies (Service Code 15)

Complete if the individual is requesting adaptive aids or mark Not applicable.

Note: Form 6507, Rationale for Adaptive Aids, Medical Supplies, and Minor Home Modifications, must be submitted with all adaptive aid and medical supplies requests. Per TAC Section 260.301, Authorization Amount and Other Limits for adaptive aids, a program provider may purchase or lease only an adaptive aid listed in the *DBMD Provider Manual*.

Fill in the space with the total dollar amount for adaptive aids, as listed on the IPC (Form 6500). **Note**: This service cannot exceed $10,000 total for one IPC year. If a request exceeds the annual cap or is not included on the HHSC approved list, the adaptive aid is denied by the HHSC program specialist and the individual is given the right to a fair hearing.

Fill in the space with the total dollar amount for adaptive aids in the Requisition Fee, as listed on the IPC (Form 6500) and as identified in the HHSC DBMD Program Payment Rates.

List of the adaptive aids or medical supplies requested -- List the adaptive aids(s) or medical supplies that are requested and include the amount for each item in the space provided. Only items listed in Section 1000, Adaptive Aids/Vehicle Modification Services, of the *DBMD Provider Manual* can be funded through the DBMD program. If additional space is needed, this section can be expanded, or an addendum can be attached. Each adaptive aid should be listed separately with a distinct price. Note that medical supplies are considered adaptive aids.

Justification for adaptive aid(s) and medical supplies -- Provide justification for each adaptive aid or medical supply based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.301-Section 260.311 regarding adaptive aids. If this is for an ongoing item, provide a breakdown of the amount of the item requested and the frequency (i.e., two packages of wipes per month in addition to those provided by Medicaid).

Are any of the requested items available through Medicaid? -- Indicate Yes or No if the items are available through Medicaid. If yes, provide an explanation of why the item is being requested through the waiver program in the justification section (i.e., Medicaid only provides two packages of wipes per month and the individual requires four total packages per month to meet the individual's needs).

Has a denial letter from Medicaid been received (if applicable)? -- Indicate if a denial letter has been received for the item. If a denial letter has been obtained, provide it as an attachment to the IPP.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

12. Dental Services (Service Code 5A)

Complete if the individual is requesting dental services or mark Not applicable.

Note: Form 6504, Prior Authorization for Dental Services, must be completed for authorization of this service, unless the request is for an initial evaluation under $200.

Fill in the space with the total dollar amount for dental services, as listed on the IPC (Form 6500). **Note**: Dental services cannot exceed $2,500 per IPC year.

Fill in the space with the total dollar amount for the dental services and dental sedation combined requisition fee, as listed on the IPC (Form 6500) and as identified in the HHSC DBMD Program Payment Rates.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service.

Mark Yes or No if the individual is less than 21 years old. If the individual is under 21, the individual must access dental services through Texas Health Steps.

Justification for services -- Provide justification for the dental service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.339, Dental Treatment. Describe whether each dental service is needed for therapeutic, orthodontic, routine preventive treatment or emergency treatment. Managed Care Organizations (MCOs) value added services **do not** need to be exhausted prior to waiver services.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

13. Dental Sedation (Service Code 5B)

Complete if the individual is requesting dental sedation or mark Not applicable.

Note: Form 6504, Prior Authorization for Dental Services, must be completed for authorization of this service, unless the request is for an initial evaluation under $200.

Fill in the space with the total dollar amount for dental sedation, as listed on the IPC (Form 6500). **Note**: Dental sedation services cannot exceed $2,000 total per IPC year.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service.

Mark Yes or No if the individual is less than 21 years old. If the individual is under 21, the individual must access dental services through Texas Health Steps.

Justification for services -- Provide justification for the dental sedation based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.339, Dental Treatment. Describe which dental service(s) requires sedation as well as the individual's specific needs which require sedation for dental services.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

14. Assisted Living

Complete if the individual is requesting assisted living services or mark Not applicable.

Indicate the type of assisted living the individual is requesting: ALF 4 to 6 bed, licensed home health assisted living or 18-hour assisted living or licensed home health assisted living.

Fill in the space with the total number of units for the requested service category (19,19E or 19F) as listed on the IPC (Form 6500).

Justification for services -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed

Enrollment IPC, and TAC Chapter 553, Licensing Standards for Assisted Living Facilities.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

15. Physical Therapy Services (Service Code 6)

Complete if the individual is requesting physical therapy services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500), and on the therapy evaluation completed by the licensed professional.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service.

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Units requested by -- Provide the name and title of the physician who is requesting this service, if ongoing. If an evaluation is being requested, it is only necessary to notate who has requested the service (i.e., the individual, another therapy provider, etc.).

Date of assessment -- Indicate the date that the therapy assessment occurred, if requesting ongoing therapy. If only requesting an evaluation or assessment, provide the date that the evaluation or assessment will occur in the future or mark Evaluation only.

Duration of therapy requested -- Document the planned duration of this therapy service (i.e., once per week for six months).

Professional providing justification -- Document the licensed therapist (name and title) providing justification for or requesting ongoing therapy services. If only an evaluation or assessment is requested at this time, mark Evaluation only.

Justification for units (from appropriate professional) -- Provide justification developed by the licensed therapist for the requested therapy services. Provide specific information regarding the individual's needs and

how this therapy meets the individual's needs, as well as the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.355, Therapies.

What plan is in place to transfer therapy services to a non-therapist service provider, changing the role of the therapist to a supervisory role? -- The therapist is required to develop and implement a plan for these tasks anytime this type of therapy is provided. If this service cannot be transferred to a non-therapist, the therapist must provide specific reasons which prevent this from happening.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Physical Therapy Schedule -- Provide the individual's physical therapy services schedule. Indicate the therapist's name who will assist the individual with physical therapy services in the first column. Provide a start time and end time for each therapist under each day of the week. Provide a total number of hours for each therapist for the week in the Total Hours column. Then, provide a weekly total number of hours for physical therapy services.

16. Occupational Therapy Services (Service Code 7)

Complete if the individual is requesting occupational therapy services or mark Not applicable.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500) and on the therapy evaluation completed by the licensed professional.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service. Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Units requested by -- Provide the name and title of the physician who is requesting this service, if ongoing. If an evaluation is being requested, it is only necessary to notate who has requested the service (i.e., the individual, another therapy provider, etc.).

Date of assessment -- Indicate the date that the therapy assessment occurred, if requesting ongoing therapy. If only requesting an evaluation or

assessment, provide the date that the evaluation or assessment will occur in the future or mark Evaluation only.

Duration of therapy requested -- Document the planned duration of this therapy service (i.e., once per week for six months).

Professional providing justification -- Document the licensed therapist (name and title) providing justification for or requesting ongoing therapy services. If only an evaluation or assessment is requested at this time, mark Evaluation only.

Justification for units (from appropriate professional) -- Provide justification developed by the licensed therapist for the requested therapy services. Provide specific information regarding the individual's needs and how this therapy meets the individual's needs, as well as the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.355, Therapies.

What plan is in place to transfer therapy services to a non-therapist service provider, changing the role of the therapist to a supervisory role? -- The therapist is required to develop and implement a plan for these tasks anytime this type of therapy is provided. If this service cannot be transferred to a non-therapist, the therapist must provide specific reasons which prevent this from happening.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Occupational Therapy Schedule -- Provide the individual's occupational therapy services schedule. Indicate the name of the therapist who will assist the individual with occupational therapy services in the first column. Provide a start time and end time for each therapist under each day of the week. Provide a total number of hours for each therapist for the week in the Total Hours column. Then, provide a weekly total number of hours for occupational therapy services.

17. Speech, Hearing and Language (Service Code 9)

Complete if the individual is requesting speech, hearing or language therapy services, or mark Not applicable.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500) and on the therapy evaluation completed by the licensed professional.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service. Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Units requested by -- Provide the name and title of the physician who is requesting this service, if ongoing. If an evaluation is being requested, it is only necessary to notate who has requested the service (i.e., the individual, another therapy provider, etc.).

Date of assessment -- Indicate the date that the therapy assessment occurred, if requesting ongoing therapy. If only requesting an evaluation or assessment, provide the date that the evaluation or assessment will occur in the future or mark Evaluation only.

Duration of therapy requested -- Document the planned duration of this therapy service (i.e., once per week for six months).

Professional providing justification -- Document the licensed therapist (name and title) providing justification for or requesting ongoing therapy services. If only an evaluation or assessment is requested at this time, mark Evaluation only.

Justification for units (from appropriate professional) -- Provide justification developed by the licensed therapist for the requested therapy services. Provide specific information regarding the individual's needs and how this therapy meets the individual's needs, as well as the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.355, Therapies.

What plan is in place to transfer therapy services to a non-therapist service provider, changing the role of the therapist to a supervisory role? -- The therapist is required to develop and implement a plan for these tasks anytime this type of therapy is provided. If this service cannot be transferred to a non-therapist, the therapist must provide specific reasons which prevent this from happening.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Speech, Hearing and Language Therapy Schedule -- Provide the individual's schedule. Indicate the name of the therapist who will assist the individual with speech, hearing and language therapy services in the first column. Provide a start time and end time for each therapist under each day of the week. Provide a total number of hours for each therapist for the week in the Total Hours column. Then, provide a weekly total number of hours for Speech, Hearing and Language Therapy Services.

18. Audiology (Service Code 35)

Complete if the individual is requesting audiology therapy services or mark Not applicable.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500) and on the therapy evaluation completed by the licensed professional.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service. Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Units requested by -- Provide the name and title of the physician who is requesting this service, if ongoing. If an evaluation is being requested, it is only necessary to notate who has requested the service (i.e., the individual, another therapy provider, etc.).

Date of assessment -- Indicate the date that the therapy assessment occurred, if requesting ongoing therapy. If only requesting an evaluation or assessment, provide the date that the evaluation or assessment will occur in the future or mark Evaluation only.

Duration of therapy requested -- Document the planned duration of this therapy service (i.e., once per week for six months).

Professional providing justification -- Document the licensed therapist (name and title) providing justification for or requesting ongoing therapy services. If only an evaluation or assessment is requested at this time, mark Evaluation only.

Justification for units (from appropriate professional) -- Provide justification developed by the licensed therapist for the requested therapy services. Provide specific information regarding the individual's needs and

how this therapy meets the individual's needs, as well as the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.355, Therapies.

What plan is in place to transfer therapy services to a non-therapist service provider, changing the role of the therapist to a supervisory role? -- The therapist is required to develop and implement a plan for these tasks anytime this type of therapy is provided. If this service cannot be transferred to a non-therapist, the therapist must provide specific reasons which prevent this from happening.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Audiology Services Schedule -- Provide the individual's audiology services schedule. Indicate the name of the therapist who will assist the individual with audiology services in the first column. Provide a start time and end time for each therapist under each day of the week. Provide a total number of hours for each therapist for the week in the Total Hours column. Then, provide a weekly total number of hours for audiology services.

19. Dietary Services (Service Code 34)

Complete if the individual is requesting dietary services or mark Not applicable.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500) and on the therapy evaluation completed by the licensed professional.

Services to be provided by -- Indicate the service provider (name and title) utilized for this service. Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Units requested by -- Provide the name and title of the physician who is requesting this service, if ongoing. If an evaluation is being requested, it is only necessary to notate who has requested the service (i.e., the individual, another therapy provider, etc.).

Date of assessment -- Indicate the date that the therapy assessment occurred, if requesting ongoing therapy. If only requesting an evaluation or

assessment, provide the date that the evaluation or assessment will occur in the future or mark Evaluation only.

Duration of therapy requested -- Document the planned duration of this therapy service (i.e., once per week for six months).

Professional providing justification -- Document the licensed therapist (name and title) providing justification for or requesting ongoing therapy services. If only an evaluation or assessment is requested at this time, mark Evaluation only.

Justification (from appropriate professional) -- Provide justification from the licensed dietician for the requested therapy services. Provide specific information regarding the individual's needs and how this service meets those needs, as well as the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.355, Therapies.

What plan is in place to transfer dietary services to a non-dietician service provider, changing the role of the dietician to a supervisory role? -- The dietician is required to develop and implement a plan for these tasks anytime this type of service is provided. If this service cannot be transferred to a non-dietician, the dietician must provide specific reasons which prevent this from happening.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Dietary Services Schedule -- Provide the individual's dietary services schedule, if applicable. Indicate the dietician who will assist the individual with dietary services in the first column. Provide a start time and end time for each dietician under each day of the week. Provide a total number of hours for each dietician for the week in the Total Hours column. Then, provide a weekly total number of hours.

20. Employment Assistance (Service Code 54)

Complete if the individual is requesting employment assistance services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Mark Yes or No if this service will be provided through the CDS option.

Justification for units -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and Section 260.341, Employment Services. Provide detailed information regarding the employment assistance activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Employment Assistance Service Schedule (if applicable) -- Provide the individual's employment assistance services schedule. Indicate the service provider name who will assist the individual with employment assistance services in the first column. Provide a start time and end time for each service provider under each day of the week. Provide a total number of hours for each service provider for the week in the Total Hours column. Then, provide a weekly total number of hours for employment assistance services.

21. Supported Employment (Service Code 37)

Complete if the individual is requesting supported employment services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Mark Yes or No if this service will be provided through the CDS option.

Justification for units -- Provide justification for supported employment services based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and Section 260.341, Employment Services. Provide detailed information regarding the supported

employment activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Supported Employment Services Schedule -- Provide the individual's supported employment services schedule. Indicate the name of the service provider who will assist the individual with supported employment services in the first column. Provide a start time and end time for each service provider under each day of the week. Provide a total number of hours for each service provider for the week in the Total Hours column. Then, provide a weekly total number of hours for supported employment services.

22. Behavioral Support Services (Service Code 43A)

Complete if the individual is requesting behavioral support services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Date of assessment -- Indicate the date that the behavioral support service provider conducted the assessment of maladaptive behavior, if requesting ongoing behavioral support services. If only requesting an evaluation or assessment, provide the date that the evaluation or assessment will occur in the future.

Mark Yes or No if the individual has a behavioral support plan in place.

Justification and breakdown for units -- Provide justification for behavioral support services based on the requirements listed in TAC Section 260.67(b)(1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.333, Behavioral Support. Provide detailed information regarding the

behavioral support activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

What plan is in place to transfer behavioral support services to a non-behavioral support service provider, changing the role of the behavioral support specialist to a supervisory role? -- The behavioral support professional is required to develop and implement a plan for these tasks anytime behavioral support services are provided. If this service cannot be transferred to a non-behavioral support specialist, the behavioral support specialist must provide specific reasons which prevent this from happening.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Behavioral Supports Schedule -- Provide the individual's behavioral supports schedule. Indicate the behavioral support professional who provides these services in the first column. Provide a start time and end time for each professional under each day of the week. Provide a total number of hours for each professional for the week in the Total Hours column. Then, provide a weekly total number of hours for behavioral support services.

23. Orientation and Mobility Services (Service Code 44)

Complete if the individual is requesting orientation and mobility services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Justification for units -- Provide justification for orientation and mobility based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.349, Orientation and Mobility. Provide detailed information regarding the orientation and mobility activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

24. Intervener Services (Service Codes 45, 45A, 45B, 45C, 45V, 45AV, 45BV, 45CV)

Complete if the individual is requesting intervener services or mark Not applicable.

Complete for each level of intervener requested (base I, II, III).

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service (an additional space is provided if there is more than one intervener provider).

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Fill in the blanks with the number of hours requested for each week, the number of weeks requested, and the total requested for that schedule.

Mark Yes or No if this service will be provided through the CDS option.

Justification for intervener units -- Provide justification for this service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and TAC Section 260.345, Intervener. Include information about how the level of intervener requested will benefit the individual.

Provide detailed information regarding the intervener activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

What would the individual like to gain from this service? -- Document for **all levels** the individual's preferred outcome from this service.

Intervener Schedule -- Provide the individual's intervener schedule, if applicable. Indicate the name of the intervener who provides these services in the first column. Provide a start time and end time for each intervener under each day of the week. Provide a total number of hours for each intervener for the week in the Total Hours column. Then, provide a weekly total number of hours for intervener services.

Provide a yearly total for each level of intervener (base I, II, III) in the spaces provided. If that level is not being requested, leave blank. If additional schedule space is needed, an addendum can be attached to this form.

25. Transportation - Residential Habilitation (Service Code 48, 48V)

Complete the information if the individual is requesting residential habilitation. If the individual is receiving Service Codes 19, 19E, or 19F, or if the individual does not require residential habilitation services, mark not applicable and leave this box blank.

Fill in the space with the total number of units for this service category as listed on the IPC (Form 6500).

Fill in the space with the total number of units of this service category utilized in the previous IPC year.

Services to be provided by -- Indicate the primary service provider in the first blank and provide any other service providers that may be utilized.

Fill in the space with the number of hours requested for each week and the number of weeks requested.

Multiply to get the total requested for that schedule. If there is only one schedule, the total will be the same as the amount on the IPC.

If there are two schedules (i.e., in-school and out-of-school schedules), provide the second schedule hours in the same format and document the reason for multiple schedules in the Justification for units.

Mark Yes or No to indicate if this service is being provided through the CDS option.

Justification for units -- Provide justification for residential habilitation based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and Section 260.343, Habilitation.

Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

Note: A service provider must not be the parent of an individual if the individual is under 18 years old. The parent of a child is considered the legally responsible adult and, as such, care provided to the child is a natural support that cannot be replaced by a waiver service.

If the hours requested have increased from the previous IPC year, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

26. CDS Services (if applicable)

Financial Management Services (FMS) -- Complete if the individual is requesting Financial Management Services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the Financial Management Agency that will be utilized for this service.

Support Consultation -- Complete if the individual is requesting support consultation services or mark Not applicable.

Fill in the space with the total number of units for this service category, as listed on the IPC (Form 6500).

Services to be provided by -- Indicate the service provider utilized for this service.

Justification for units -- Provide justification detailing the need for support consultation services. Provide detailed information regarding the support

consultation activities that will be provided, and a breakdown of units needed for each activity. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC Form 6500) must be the same.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service. Indicate any preferences or special considerations identified during the discovery process or the completion of this tool. This could include the individual prefers to take baths over showers, or factors such as behaviors which result in higher support needs.

27. DBMD Outcomes

The outcome **must** be documented under each of the following categories: Intervener, Residential Habilitation, Day Habilitation, Individualized Skills and Socialization, Assisted Living Services and CFC PAS/HAB.

Communication Outcomes -- Document outcomes developed by the SPT, based on the individual's preferences and related to the individual's ability to effectively communicate wants and needs in TAC Section 260.65, Development of an Enrollment IPP.

Choice Outcomes -- Document outcomes developed by the SPT, based on the individual's preferences and related to the implementation of the individual's choice in TAC Section 260.65, Development of an Enrollment IPP.

Active Participation Outcomes -- Document outcomes developed by the SPT, based on the individual's preferences and related to the individual's active participation in activities of daily living to the extent of the individual's ability in TAC Section 260.65, Development of an Enrollment IPP.

Access to the Community Goals -- Document outcomes developed by the SPT, based on the individual's preferences and related to the individual's ability to access and participate in community activities in TAC Section 260.65, Development of an Enrollment IPP.

Orientation and Mobility, Safety Outcomes -- Document outcomes developed by the SPT, based on the individual's preferences and related to the individual's ability to move safely and efficiently within the home and

community settings in TAC Section 260.65, Development of an Enrollment IPP.

Other Outcomes -- Document outcomes developed by the SPT, based on the individual's preferences and related to the individual's services in TAC Section 260.65, Development of an Enrollment IPP.

28. Goals -- Describe goals in measurable and observable terms (based on what the individual would like to gain from this service). Document the individual's goals in measurable and observable terms, with the anticipated time frame for accomplishing the goals and the person responsible for ensuring the goal is worked on and progress or lack of progress is documented. The goals should be clearly related to the individual and meet the individual's preferred outcome for DBMD services.

29. Protective Devices

Complete if the individual has a need for a protective device (PD) or mark Not applicable.

Mark Yes or No if the individual has a need for a PD.

What type(s) of PD does the individual have? -- Document the type(s) of PDs the individual has. Mark Yes or No if there is a written service plan for the PD that was developed by the SPT and signed by a physician, as described in TAC Section 260.215, Protective Devices. This is a requirement prior to the use of a PD.

What is the medical condition that necessitates a PD? -- Document what medical condition requires the use of a PD in line with TAC Section 260.215, Protective Devices. **Note**: PDs must not be used to modify or control behavior.

Mark Yes or No if a less restrictive method could be effective for the condition listed and explain in the space provided.

Document what less restrictive methods were considered in the space provided.

How frequently should the PD be monitored? -- Document the frequency based on a decision made by the SPT, including the RN, LAR and other professional personnel.

Who is responsible for monitoring the PD? -- Document who is responsible based on a decision made by the SPT, including the RN, LAR and other professional personnel. The person responsible must monitor the PD in line with the PD written service plan.

Is the PD contributing to the health and welfare of the individual? -- Document if the PD is contributing to the individual's health and welfare. If it is not, the SPT should discuss discontinuing use of the PD.

Mark Yes or No to indicate if the SPT reviewed and approved the PD service plan. If no is marked, explain in the space provided. The SPT must agree on the PD service plan for continued use of the PD.

30. Restraints

This section should only be completed for individuals in a DBMD residential setting.

Mark Yes or No if a physician has authorized use of the restraint(s). If yes, answer the following:

- Document the physician authorized restraints.
- Document the physician who authorized duration of the restraint.
- Document the physician authorized circumstance(s) under which restraint may be used.
- Mark Yes or No if a less restrictive method could be equally effective to restrain and explain in the space provided.

Document what less restrictive methods were considered.

31. Non-waiver Resources

Document any non-waiver resources in which the SPT attempted to access through family, friends or other non-waiver resources in the community (i.e., family, community resources, Medicaid, Medicare, private insurance) and the outcome of the attempt (i.e., individual was denied service, no non-waiver services available to meet the need, service could only partially meet the individual's needs, etc.).

Document any non-waiver resources (any support service provided by family or friends or obtained from other non-waiver resources in the community that the individual or SPT is currently accessing (i.e., family, community resources, Medicaid, Medicare, private insurance).

32. Case Manager Contact Information

Fill in the space with the individual's name and indicate that the individual has been provided the case manager's name, contact information and the afterhours numbers (filled in) in the spaces provided.

33. Review of Individual's Records and Consents

Verify by marking each box that the required records and consents have been reviewed with the SPT. Mark the box that the individual or LAR received copies of these documents.

34. Review of Individual's Records and Consents

Document by marking all boxes that apply for the assessments which have been reviewed with the SPT. Document the date the Adaptive Behavior Level assessment was completed and the individual's Adaptive Behavior Level. Provide any additional information that is relevant to the IPC that is not provided elsewhere in this form.

Signatures of the SPT

The individual, LAR, case manager, program director, nurse, and other SPT members present, as selected by the individual, sign and date the form certifying the SPT is in agreement that the information documented is complete and accurate, and the services are needed by the individual.

Fill in the space to document the date and which specific documents were provided to the individual or LAR.

Individual Program Plan Revision Addendum

The addendum is completed in the same general manner as the full IPP.

Program Provider's Name -- Enter the program provider's name.

1. ***General Information*** -- Enter the name of the individual, date of enrollment, date of team meeting, date of birth, Social Security number,

IPC effective period, Medicaid number and Medicare number, if applicable.

2. ***Service Planning Team (SPT) Members Present*** -- Enter the names of the individual, LAR, program director, service provider, nurse, case manager and others.

3. ***Justification for DBMD Service(s)*** -- Indicate the service type being revised. If multiple services are being revised, multiple copies of this form can be submitted together. Fill in the space with the total number of units for this service category, as listed on the revised IPC (Form 6500).

Mark the appropriate box to indicate if the service being revised is a CFC service or a waiver service.

If only support management is being added, fill out the information up to this point on the form, check the box and no further information is needed. Only the individual and the case manager's signatures are needed to add support management.

Services to be provided by -- Document the name of the day habilitation center that will be utilized for this service. Fill in the space with the total number of units of this service category authorized on the current IPC.

Mark the appropriate box to indicate if this is an increase or decrease in the units from the currently authorized IPC.

Current IPC -- Fill in the space with the currently authorized number of hours requested for each week and the number of weeks requested and the total requested for that service, or mark NA if a schedule does not apply to the service being added.

Revised IPC -- Fill in the space with the revised number of hours requested for each week and the number of weeks requested and the total requested for that service, or mark NA if a schedule does not apply to the service being added.

Mark Yes or No if this service will be provided through the CDS option.

Mark Yes or No if this service is critical to health and safety. If yes, a backup plan must be completed.

Date of assessment -- Enter the date or mark NA.

Mark Yes or No of NA if the individual has a behavioral support plan in place.

Justification -- Provide justification for the service based on the requirements listed in TAC Section 260.67(b) (1-6), Development of a Proposed Enrollment IPC, and the applicable TAC for that service.

Provide detailed information regarding the activities that will be provided through this service and a breakdown of units needed for each activity, if applicable. Use this breakdown to determine the number of units needed on the IPC. This total and the number of units on the IPC (Form 6500) must be the same.

If an increase is requested, document the changes that require this increase.

What would the individual like to gain from this service? -- Document the individual's preferred outcome from this service.

Special Considerations or Preferences -- Document any special considerations or preferences.

4. ***Outcomes*** -- Document any new or revised outcomes in the sections, if applicable. Note: If you are adding intervener, day habilitation, residential habilitation and residential services as a new service for that individual's IPC, outcomes must be documented in each category (excluding other).

5. **Goals** -- Document the goals in measurable and observable terms (based on what the individual would like to gain from this service), with the anticipated time frame for accomplishing the goals and the person responsible for ensuring the goal is worked on and progress or lack of progress is documented. The goals should be clearly related to the individual, meeting the preferred outcomes for DBMD services.

6. **Important Schedules** -- Provide any schedules important for the authorization of the service being revised, if applicable. Indicate the

service type in the first column. Provide a start time and end time for each service type under each day of the week. Provide a total number of hours for each service type for the week in the Total Weekly Hours column. Provide any additional information that is relevant to the IPC that is not provided elsewhere in this form.

Signatures of the SPT

The individual, LAR, case manager, program director, nurse and other SPT members present, as selected by the individual, sign and date the form certifying the SPT is in agreement that the information documented is complete and accurate, and the services are needed by the individual.

Fill in the space to document the date and which specific documents were provided to the individual or LAR.