PRINCE GEORGE'S PROVIDER COUNCIL
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PGPC INTERAGENCY STANDING COMMITTEE

Plan Review Cover Sheet

[please print or type]

Person's initials _____ Date of birth _____

Residential service provider _____

Present Day service provider _____

Present Person responsible for packet:

Name _____ Title _____ Phone _____

Date Plan was developed _____ ☐ New plan ☐ Renewal ☐ Revised

Date of last revision _____ Date Plan was reviewed by team _____

Reason for IASC Review: ☐ A-Restrictive Measure ☐ B-Psychoactive Drug ☐ C-Financial Restitution

Potential risk if not implemented per PCP: _____

Committee Decision:

☐ Approved *(plan must be re-submitted when any substantive changes are made)*

☐ Conditionally approved _____

☐ Not approved _____

Signature of Chairperson _____ Date reviewed _____

Comments:

Guidelines for submission:

- ✓ Required IASC forms must be fully complete
- ✓ Person's name is confidential – plan and supporting documents must contain only initials
- ✓ IASC forms with plan and supporting documentation must be mailed to Committee members a minimum of 14 days prior to the date of the IASC meeting in order to be reviewed at that time
- ✓ Someone who is familiar with the plan and the person who's plan is to be reviewed must be present for the review

SECTION A: USE OF RESTRICTIVE TECHNIQUE IN BEHAVIOR PLAN Person's initials _____ _____

[print/type]

Date form completed _____ _____ Person's primary communication method _____

[select closest option]

Level of participation in plan development _____ / explain response below:

List each restrictive technique and the corresponding challenging behavior(s):

List each behavioral objective with criteria for fading the restrictive measure:

Explain the adaptive alternative behavior/skills to be introduced:

What is the potential outcome if the restrictive measure(s) is not used/Risk to person or others:

What are potential risks incurred by use of technique used/Risk to person or others:

Informed Consent to use restrictive technique(s) obtained from: [must have at least one]

Person served _____ Estimated level of understanding _____

_____

[signed initials]

Proponent _____ Relationship _____

_____

[signature]

NOTE: Guardian **must** sign if court adjudicated; otherwise, proponent should be the surrogate decision-maker (HG §5-605), independent advocate, or CCS; may not be provider agency employee unless extenuating circumstances.

SECTION B-PART 1: USE OF PSYCHOACTIVE DRUG IN BEHAVIOR PLAN

-This form is to be completed <u>after</u> meeting with prescribing physician-

Person's initials _____
[print/type]

Date form completed _____ Person's primary communication method _____
[select closest option]

Level of participation in plan development _____/ explain response below:

List each psychoactive drug prescribed and the corresponding challenging behavior(s): ⩚

List each behavioral objective with criteria for fading the medication:

Explain the adaptive alternative behavior/skills to be introduced:

What is the potential outcome if the medication(s) is not used/Risk to person or others:

What are the potential risks for the person as a result of the use of each medication:

Informed Consent to use psychoactive drugs(s) obtained from: [must have at least one]

Person served _____ Estimated level of understanding: _____

_____
[signed initials]

Proponent _____ Relationship _____

_____
[signature]

NOTE: Guardian **must** sign if court adjudicated; otherwise proponent should be the surrogate decision-maker (HG §5-605), independent advocate, or CCS; may not be provider agency employee unless extenuating circumstances.

SECTION B-PART 2: USE OF PSYCHOACTIVE DRUG IN BEHAVIOR PLAN Patient's initials _____

-This form is to be completed and signed by the prescribing physician- *[print/type]*

Patient's date of birth _____ Supporting Agency _____

NOTE TO THE PHYSICIAN: Completion of this form enables Agency compliance with State regulations [COMAR 10.22.10.07] governing the use of medications to modify behavior in persons authorized for services by the Maryland Department of Health/Developmental Disabilities Administration, when the medication is not solely for the treatment of a psychiatric disorder diagnosed in accordance with the DSM V (or most recent edition).

	Medication #1	Medication #2
Medication/Dose:		
Behavior(s) targeted by this medication:		
Possible side effects and/or potential risks associated with this medication:		
How is effectiveness of medication determined?		
Conditions under which you would consider decreasing this dose:		
Conditions under which you would discontinue this medication:		
Recommended frequency of medication review:		
Special concerns or notes:		

Additional medications on reverse

Physician Name *[please print]* Signature Date

Patient's initials _____
[print/type]

Patient's date of birth _____ Supporting Agency _____

	Medication # 3	Medication #4
Medication/Dose:		
Behavior(s) targeted by this medication:		
Possible side effects and/or potential risks associated with this medication:		
How is effectiveness of medication determined?		
Conditions under which you would consider decreasing this dose:		
Conditions under which you would discontinue this medication:		
Recommended frequency of medication review:		
Special concerns or notes:		

Physician Initials _____

SECTION C: POTENTIAL FINANCIAL RESTITUTION IN BEHAVIOR PLAN Person's initials _____
[print/type]

Date form completed _____ Person's primary communication method _____
(*Select closest option)*

Agency affirms compliance-*COMAR 10.22.02.10A(11*) _____ Regional Dir. Notified _____

Level of participation in plan development_____ / explain response below:

Describe the specific nature and history of all challenging behavior(s) that may result in property damage:

How is the person's ability to pay for damages determined, including the cap on amount:

List each behavioral objective with criteria for fading use of this measure:

Explain the adaptive alternative behavior/skills to be introduced:

What is the potential outcome if this measure(s) is not used/Risk to person or others:

What are potential risks incurred by use of this measure/Risk to person or others:

Informed Consent for restitution obtained from: [must have at least one]

Person served _____ Estimated level of understanding: _____

_____
[signed initials]

Proponent _____

_____ Relationship _____
[signature]

NOTE: Guardian **must** sign if court adjudicated; otherwise, proponent should be the surrogate decision-maker (HG §5-605), independent advocate, or CCS; may not be a provider agency employee unless extenuating circumstances.