Washington State Department of Social & Health Services
Transforming lives

To: Date:

From:

CLIENT NAME	DATE OF BIRTH

Verification of Waiver Funding (all must apply)

- ☐ All benefits under the Medicaid State Plan, private health insurance, and other services have been used.
- ☐ Identified services do not replace or duplicate any paid or unpaid supports and services.
- ☐ Services address a need identified in the waiver participant's Person Centered Service Plan.
- ☐ The Person Centered Service Plan (PCSP) is attached.

ADDITIONAL INFORMATION / SPECIAL INSTRUCTIONS (PROVIDE ANY ADDITIONAL INFORMATION NOT ALREADY INDICATED IN THE PCSP)

REQUESTED PROVIDER ACTIONS

Behavior Support:

- ☐ Conduct and write Functional Assessment
- ☐ Develop written Positive Behavior Support Plan
- ☐ Implement and train staff / family / caregiver on Positive Behavior Support Plan
- ☐ Analyze data, review and revise current Positive Behavior Support Plan
- ☐ Create data collection tools / review of tools / revision
- ☐ Participate in CIIBS Child, Family Team (CFT) meeting
- ☐ Observation of client

Counseling:

- ☐ Conduct assessment and written evaluation of client (counseling related)
- ☐ Counseling – Individual (example: client, mother, father, sibling)
- ☐ Counseling - Group
- ☐ Counseling – Family

Consultation / Training:

- ☐ Consult with Case Resource Manager before contacting client/caregiver
- ☐ Request visit with caregiver
- ☐ Consultation with ☐ Client ☐ Family ☐ Staff ☐ Other Caregiver (specify):
- ☐ Staff / family training
- ☐ Other:

Approved Funding

VENDOR CONTRACT RATE	FREQUENCY (ONE TIME, WEEKLY, MONTHLY, ETC.)	NOT TO EXCEED
		hours or $

Duration: Begin Date End Date (not to exceed annual plan date)

Provider Reports

The Behavior Support, Counseling, and Consultation Services contract requires submission of certain assessments, plans, and reports. Plans and progress reports must conform to the contract specifications and are due as described in the provider's contract or otherwise directed by DDA. Payment will not be authorized without receipt of these reports.

Please submit: ☐ Monthly ☐ Quarterly ☐ Other:

APPROVED BY:	CASE RESOURCE MANAGER	DATE

☐ Supporting Documents Attached
Copy to File

Instructions for Memo to Provider for Behavior Support, Counseling, and Consultation Services

<u>This form is optional</u>.

When do I use this memo?

Complete this memo after you have received approval to authorize one of these service and State Plan Services have been exhausted. Attach this memo to the PCSP and send it to the identified service provider.

Why do I need to use this memo?

You are responsible for the oversight of planned services. It is important to communicate what services you expect from the service provider and their reporting requirements.

Who completes this form?

The case manager is responsible for filling out this form prior to authorizing services.